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DEPARTMENT OF VETERANS AFFAIRS CONSTRUCTION REQUEST FOR FY 1990

HEARING

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

FEBRUARY 1, 1989

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DEPARTMENT OF VETERANS AFFAIRS CONSTRUCTION REQUEST FOR FY 1990

Wednesday, February 1, 1989

House of Representatives,
Subcommittee on Hospitals and Health Care,
Committee on Veterans Affairs,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9 a.m., in room 334, Cannon House Office Building, Hon. G.V. (Sonny) Montgomery (chairman of the subcommittee) presiding.

Present: Representatives Montgomery, Rowland of Georgia, Kanjorski, Stenholm, Harris, Kennedy, Patterson, Johnson, Jontz, Payne, Hammerschmidt, Rowland of Connecticut, and Ridge.

OPENING STATEMENT OF CHAIRMAN MONTGOMERY

Mr. Montgomery. Good morning. The subcommittee hearing will come to order.

The purpose of our meeting this morning is to receive testimony about the VA's proposed construction budget and plans for fiscal year 1990. This is the first hearing of the 101st Congress for our subcommittee.

Some people are surprised that the first topic is construction. Well, the reason for that is that, under current law, appropriations may not be made for construction projects in the VA that cost more than $2 million and leases that cost more than $500,000 until such projects are authorized by the House and Senate Veterans Affairs Committees.

Second, construction really has a direct effect on the amount of quality of medical care this is delivered by the VA. You have got to have the proper physical facilities to get the job done.

Therefore, we include construction items in our report to the Budget Committee. That report is due on February 25, so you see we really haven't got much time.

Third, construction issues are always of great interest to Members, so we are providing a full hearing early in the session. I hope that we can then devote the other hearings on February 7 and 9 to address the budget for VA medical care without really having to tackle again construction projects again. The medical care budget situation is very tough, as you know.

We plan to discuss specific projects today, both those in the proposed budget and those that are not included. We want to know the basis for including some projects and excluding others. We are especially interested in the roles of the 5-year construction plan and the recent capital facilities assessment. We are interested in learning whether the recommendations of the Department of Medicine and Surgery are, indeed, taken by the Office of Facilities. Last, we would like to look into the new program called the Facilities Development Plan which is designed to make sense of construction planning in the VA.

Each year we have witnesses to come forward, and you do help us. If you're here on the engineering phase, if you would simplify it for us and use simple building terms that we can understand, it would certainly help the subcommittee.

Now, if Paul Kanjorski, a member of this committee, has no objections, I am going to recognize John Paul Hammerschmidt, the ranking minority member, and then recognize our good friend, Charles Bennett, who has to go back to the Armed Services Committee.

At this time, John Paul Hammerschmidt, the ranking minority member on the subcommittee, is recognized.

OPENING STATEMENT OF HON. JOHN PAUL HAMMERSCHMIDT

Mr. HAMMERSCHMIDT. Thank you very much, Mr. Chairman.

You know, as we begin our subcommittee work on behalf of veterans for the 101st Congress, we are faced with one of the most difficult funding situations to confront veterans in many, many years. They are depending on us. Sonny, I know we can count on you and they can count on you to continue your unwavering leadership as chairman of the Hospitals and Health Care Subcommittee and, of course, as chairman of the full committee. As ranking member of the subcommittee, I pledge you will have my full cooperation and support in a bipartisan effort to obtain necessary funding for VA health care.

Of course, the VA's excellent doctors, nurses, and other health care professionals cannot do their job if they do not have the proper tools, including state-of-the-art facilities. In the long run, we cannot afford to have the VA's current funding shortfalls consume its future. Without an adequate physical plant, the VA will become second rate in medicine and the Nation will not be able to keep its commitment to veterans.

So, Mr. Chairman, I join you in welcoming this morning's witnesses. I look forward to working with you and with Bob Stump, the committee's new ranking member in this Congress. I know Bob would be here but he is consumed with the interest in the prayer breakfast this morning, which happens tomorrow morning, and I know, as chairman of that, he's very busy.

Mr. Chairman, before Charlie begins and before Mrs. Livingstone begins her testimony later, I want to express my appreciation for the outstanding job that she has done as the VA's Assistant Deputy Administrator for Logistics. I don't know what her plans may be with the new administration, but she certainly deserves the gratitude of this subcommittee and of all veterans for her herculean efforts to rationalize and improve the VA's construction operations. I think she has led the way in moving toward that goal and I commend her for it.

I want to join you, Mr. Chairman, in a warm welcome to our very, very distinguished first witness, a distinguished veteran himself, Charlie Bennett of Florida. Thank you, Mr. Chairman.

Mr. MONTGOMERY. Thank you, John Paul. If there have been any problems, you have always given the chairman your full support. I thank you for that and look forward to working with you as the ranking minority member on this subcommittee.

Our first witness this morning is Charles Bennett of Florida. As John Paul said, he is a combat veteran who fought in the Pacific. He is a wounded veteran. He is the ranking member on the House Armed Services Committee, one of the ranking Members of Congress of the United States. Charlie Bennett, we are honored that you are testifying before this subcommittee on veterans construction at our different facilities.

Charlie Bennett.

STATEMENT OF HON. CHARLES E. BENNETT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. BENNETT. Thank you. I am deeply grateful to you and to the committee for hearing me this morning, and I appreciate those fine remarks you made as well. You deserve them much more than I do.

There is a serious shortage of Veterans Administration facilities in Florida, and in Jacksonville in particular. Jacksonville, which I represent, is the most populous city in Florida without a VA hospital. In all fairness to the veterans of the area, a veterans hospital should be established in Jacksonville.

During the past decade, Florida has experienced a greater rate of growth in its veteran population than any other State in our Nation. With this expansion, along with a growing population base, comes the need to provide medical care and services that are mandated by law for veterans.

My bill, H.R. 78, provides for a Veterans Administration general medical and surgical hospital in Jacksonville, FL.

Jacksonville has one of the largest concentrations of retired and active duty personnel of any metropolitan area in the Nation. Its surrounding area has the third largest concentration of veterans in the State of Florida. This is projected to remain steady for many years to come. Yet, the nearest veterans hospital for this major concentration of veterans is more than a three-hour round trip away. Gainesville and Lake City, the two nearest cities with VA hospitals, do not even have significant military or veterans presence such as Jacksonville has.

The increasing age and increasing numbers of Florida veterans will increase demand, very naturally. In the future, Americans are projected to live longer and demand more services, and more of them are coming to Florida. As the average age of the veteran population increases and the demands of the system grow, we must locate a veterans hospital in the Jacksonville area, one of the primary concentrations of veterans in the United States. This is partly true because of the large number of active duty personnel in Jacksonville, about 40,000 of them on active duty at four major military concentrations in the area. They tend to retire to the area.

The Veterans Administration declares that its systematic planning efforts are designed to assure that VA facilities are located where the need is greatest. I'm sure that is so. Having VA hospitals an hour-and-a-half away from the State's largest concentration of veterans, though, it seems to me, is unconscionable. Veterans health care needs in northeast Florida or Duval County now require the establishment of a veterans hospital in Jacksonville, which has the same boundaries as Duval County.

I point out that this bill is different from the previous bills I have introduced through the years to establish such a VA hospital in Jacksonville. First, it no longer contains the requirement that the VA must seek to cooperate with the University of Florida in the University's activities in Jacksonville. Second, it no longer requires it be a 500-bed hospital. These two items are apparently an anathema to the VA, which told me in a letter that when it builds a new VA hospital, it needs to have the flexibility to determine, on its own, matters such as these.

I am grateful for these hearings, and I hope the committee will approve the establishment of this hospital that for many years has been needed. I would appreciate it very much if that could be accomplished.

I am very sorry that I do have to run, but as you know, I am bidding for a subcommittee chairmanship and its open now.

Mr. MONTGOMERY. Thank you very much, Charlie. We appreciate you appearing before the subcommittee.

As you know, a number of the veterans are moving south, and especially into Florida. We are looking at Palm Beach and East Central Florida, and we certainly will consider the Jacksonville area. Thank you very much.

Mr. BENNETT. Thank you.

Mr. HAMMERSCHMIDT. Charlie, let me just say thank you, and let me remind you that Florida is now very well represented on this committee. We have three Members from Florida.

Mr. BENNETT. Thank you.

Mr. MONTGOMERY. Paul Kanjorski, who is a member of this committee, a good member, would like to testify now about VA construction.

Before that, I would like to ask unanimous consent that Tom Carper of Delaware and Congressman Tom Lewis of Florida, as well as the Disabled American Veterans, be permitted to submit a statement for inclusion in the hearing record. Without objection, so ordered.

[The statements appear on pp. 52, 53, and 54.]

Mr. HAMMERSCHMIDT. Mr. Chairman, let me also make that same request on submitting a statement for Bob McEwen and Mike Bilirakis.

Mr. MONTGOMERY. Without objection, so ordered.

[The statement of Hon. Bob McEwen and Hon. Michael Bilirakis appear on pp. 118 and 123.]

Mr. MONTGOMERY. Paul Kanjorski, a member of this committee and a member of this subcommittee, from the 11th District of Pennsylvania.

STATEMENT OF HON. PAUL E. KANJORSKI, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. Kanjorski. Thank you, Mr. Chairman. If you will excuse me for not taking the witness chair, I will give my testimony right from the platform.

Mr. Chairman, it is a pleasure to follow someone like Charlie Bennett. I have a little story about that when I do follow him like this. I had the opportunity to serve him as a page in 1953 and 1954, when he, together with Jamie Whitten and Peter Rodino, were relatively young Members. Having served him then as a page and now to serve with him as a peer, is quite an honor for a young man such as myself. As you notice, I now cloak myself as still being a young man.

Mr. Montgomery. I think you were hinting was I there then. I was not.

[Laughter.]

Who was your sponsor?

Mr. Kanjorski. Congressman Ed Bonnet of Pennsylvania. That was 1953, the 83rd Congress.

Mr. Montgomery. Thank you.

Mr. Kanjorski. Thank you very much, Mr. Chairman, for the opportunity to testify today on the need to authorize the Wilkes-Barre, PA Veterans Administration Medical Center modernization and renovation projects.

This facility has very serious fire, health and safety deficiencies which must be corrected. Unfortunately, the Veterans Administration has delayed action on these projects for over a decade and does not intend to make a funding request until 1992. These delays deny veterans quality care, threaten their safety, and increase the cost of these projects to the taxpayers. Only an authorization from this committee can end these unnecessary delays.

According to officials at the Veterans Administration, the Wilkes-Barre facility serves 270,000 veterans in our area. It is projected that the outpatient workload will increase from the current 111,000 annual visits to over 126,000 visits by 1994. The 1950 design of the medical center is undeniably inadequate to serve the health needs of the aging veteran population of the area.

According to hospital officials, the facility violates Federal, State and local fire codes. The existing sprinkler system does not provide adequate protection. The number of smoke detectors is inadequate. The fire exits are too far from the hospital beds to allow patients sufficient time to evacuate in the event of an emergency.

There are significant health hazards that exist. The air-conditioning unit provides insufficient exchange of air to not only remove the stagnant air, but also to decrease a buildup of bacteria, further diminishing patient safety.

The quality of care that can be provided is also insufficient. There are space shortages in nearly every service ranging from radiology and cardiac care to respiratory and dialysis care. There are as many as 16 patients in one room. Outpatients must wander through the hospital, including wards, in order to locate outpatient facilities. In addition, the general admitting entrance also acts as the emergency entrance. Patient privacy deficiencies must be addressed and outpatient facilities must be consolidated.

The modernization and renovation projects go hand-in-hand. The modernization project, estimated to cost $47.5 million, involves the construction of a new wing and will address the deficiencies in admitting, outpatient and related clinical services. It will free up the space that's necessary for the renovation program. The renovation program is estimated to cost $16.1 million, and will address the fire and safety deficiencies, and will provide a modern air-conditioning system.

The Veterans Administration has dragged its feet on these projects. Correction of the fire and safety deficiencies was first proposed by the Wilkes-Barre hospital in 1977. The outpatient facility correction was proposed in 1979. However, in 1984, approval was only given for advanced planning of these projects. It took 7 years for the VA to approve and begin the planning of the initial project.

The VA presently has been "advance planning" for 4 years. Yet it does not intend to hire contractors to design even the preliminary plans until June of 1989. Perhaps most indicative of the VA's delay tactics is that it does not intend to request funding for design/construction until 1992. That means that despite the fact it only takes 10 to 12 months to complete the preliminary design, which should clear the way for the working design by early 1990, according to the VA's own schedule, the VA intends to delay it until 1992, an extra 2 years.

It is important to emphasize that the VA has determined that modernization, which will physically expand the VA facility and consolidate outpatient facilities, must be done before fire and safety problems can be addressed. Therefore, if all goes well according to the VA's elongated schedule, the corrections to serious fire and safety deficiencies will not even be begun until 1993, and that will continue on until 1994 and 1995.

I understand that this committee must be mindful of existing budget constraints. Otherwise, it may lose its credibility. However, the Veterans Affairs Committee must maintain its authority to set priorities and authorize projects according to real needs. Given the serious space, health, and fire safety deficiencies that must be corrected at the VA medical center in Wilkes-Barre, PA, and given the long delay in beginning these projects, I think it is clear that the completion of these projects is a top priority. Further, the total expense of these projects, $63.6 million, although significant, will not break the budget.

In the last Congress, this subcommittee held a hearing concerning 13,000 VA beds taken out of service. At that hearing it became clear that the VA experienced severe budget shortfalls and that the Administrator had not requested funding reflective of real needs. The fiscal year 1990 budget request has regrettably demonstrated a continuation of this policy. It is incumbent upon this committee and us to request realistic funding. If we fail to request funding for the modernization and renovation of the Wilkes-Barre facility, we will be guilty of the very same misjudgment as the past administration.

Mr. Chairman, colleagues, I respectfully request that you support adding these projects to those to be authorized by the fiscal year 1990 construction resolution.

Thank you, Mr. Chairman.

[The prepared statement of Congressman Kanjorski appears at p. 61.]

Mr. MONTGOMERY. Thank you very much, Paul.

As I understand it, this is renovation on the Wilkes-Barre VA hospital there, to move it from 1992 to 1990, around $50 million?

Mr. KANJORSKI. Yes, Mr. Chairman. There has been a constant delay over the last 10 years. Actually, one of the major problems is that we're hitting our high peak in veterans, as everywhere else in the country. This part of Pennsylvania happens to be the oldest Congressional District outside the State of Florida per capita. I said, we literally have 16 people in the hospital rooms. There is stagnant air that's unimaginable, and it's a 40-year old facility which has undergone no modernization.

Mr. MONTGOMERY. Thank you.

John Paul.

Mr. HAMMERSCHMIDT. Mr. Chairman, let me just say to Paul for the record here—you wrote a letter describing the case there at Wilkes-Barre?

Mr. KANJORSKI. Yes.

Mr. HAMMERSCHMIDT. And I think you have a good case. I said so in my response, but I would like to put that on the record. I hope within the parameters of the funding and constraints that exist that you can upgrade the date quicker than 1992, if at all possible. I would support that.

Mr. KANJORSKI. Thank you very much.

Mr. MONTGOMERY. I would like to thank my Democratic colleagues for your attendance this morning. Only two are missing from our subcommittee on this side of the aisle. And we expect a good attendance on the Republican side.

Mr. ROWLAND OF CONNECTICUT. It's quality, not quantity, over here.

[Laughter.]

Mr. MONTGOMERY. Are there any other comments on the proposal at the Wilkes-Barre facility? If not, thank you very much, Paul. You might want someone to ask questions of our witnesses from the VA, which I will call up at this time.

Mr. KANJORSKI. I appreciate that.

Mr. Chairman, I'm going to have to excuse myself. I'm on the Banking Committee and we are reorganizing this morning, also.

Mr. MONTGOMERY. Okay. Some of us have that same problem on other committees. I want to thank you again.

We will have next Mrs. Susan Livingstone, Associate Deputy Administrator for Logistics, Veterans Administration, accompanied by Dr. Gronvall, Dr. Lewis, Mr. Neumann and Mr. Neary. Susan, when you get up to the table, introduce the witnesses with you today. As I understand it, you're the Acting Administrator today, that Acting Administrator Tom Harvey is out of the mainland and you're taking over. Congratulations.

Mrs. LIVINGSTONE. Yes, sir, that's correct, for the next three days.

Mr. STENHOLM. Mr. Chairman.

Mr. MONTGOMERY. Charlie Stenholm of Texas.

Mr. STENHOLM. Mr. Chairman, if I might, I'm going to have to excuse myself for duties on another committee in just a moment. I have a statement and two questions that I would like to submit for the record at this point.

Mr. MONTGOMERY. Without objection, so ordered. We certainly hope you could get some logical answers back on these questions.

I would hope that the staff, once we get these answers back, will get them to Members. I know sometimes we submit questions—not especially this committee, but other committees—and you never hear from anybody again.

Thank you, Charlie. Without objection, so ordered.

Mr. STENHOLM. Thank you.

Mr. MONTGOMERY. Are there any other comments? If not, proceed, Mrs. Livingstone.

STATEMENT OF SUSAN LIVINGSTONE, ASSOCIATE DEPUTY ADMINISTRATOR FOR LOGISTICS, VETERANS ADMINISTRATION; ACCOMPANIED BY JOHN GRONVALL, M.D., CHIEF MEDICAL DIRECTOR; ARTHUR LEWIS, M.D., DEPUTY CHIEF MEDICAL DIRECTOR; GERALD E. NEUMANN, DIRECTOR, OFFICE OF FACILITIES; AND ROBERT NEARY, DIRECTOR, OFFICE OF PLANNING AND DEVELOPMENT, OFFICE OF FACILITIES

Mrs. LIVINGSTONE. Thank you, Mr. Chairman. We are very pleased to be able to appear before the subcommittee this morning to present our testimony concerning the Department of Veterans Affairs fiscal year 1990 construction budget request.

With your permission, Mr. Chairman, I would like to submit my full statement for the record and just briefly summarize a few points.

First of all, I would like to introduce those at the table with me today. At the end is Mr. Bob Neary, who is Director of our Office of Planning and Development in the Office of Facilities. Sitting next to him is Dr. Arthur Lewis, who is the Deputy Chief Medical Director. Immediately to my right is Dr. John Gronvall, our Chief Medical Director at the VA. And over on my left is Mr. Gerald Neumann, who is Director of the Office of Facilities at the Veterans Administration.

Mr. Chairman, as you know, the Department of Veterans Affairs has the largest medical facility construction program in the Nation, both the Federal and private sector included. This does include a tremendous capital investment of about 5,000 buildings and some 27,000 acres of land.

It is very critical to the VA's mission that we preserve, maintain and enhance this physical plant to ensure that it has the capability to deliver state-of-the-art medical care, and also to respond to the changing needs of the Nation's veterans.

This fiscal 1990 budget request represents a construction program level request of $487.623 million. Of this total, about $413 million is for medical care projects. Although this is a slight decrease over what we requested in fiscal 1989, we believe our fiscal

1990 budget request represents a reasonable level, given the general budget constraints that faced all Federal agencies this year.

We are very proud of our construction program, Mr. Chairman, in the Veterans Administration. As you know, with your support and the backing of this committee over the years, for the 5 past years specifically, we have received $3.3 billion in support of the VA's construction program. In actual dollars, this is about an 18-percent increase over the previous 5-year period, and in terms of real dollars, converted to today's dollars, it represents a stable level for the construction program over the last 5 years.

The fiscal year 1990 construction request is a product of the planning and development efforts of numerous offices within the Veterans Administration. As you referenced in your opening remarks, we are embarking on a very significant improvement in our construction planning program which will result in more uniform and consistent planning data and also improve documentation of the decisions we make in terms of the projects that will be funded. This process is called the Facility Development Planning Process.

Within our advanced planning fund request for fiscal year 1990, we requested $10 million as the final increment to complete this planning initiative. Basically, these facility development plans, which we call FDP's, will provide the VA for the first time ever with a comprehensive nationwide assessment of our facility needs to the year 2000 and beyond.

Tremendous benefits will be forthcoming from this facility development planning program. The most important of these benefits is providing the veterans of this Nation with appropriate facilities in the right place and at the right time. We feel very positive about this planning effort, and I would suggest that the $280,000 to $300,000 estimate for each one of these facility development plans, or FDP's, is a very reasonable investment. Indeed, the total cost of the effort, which is estimated at $40 million, of which Congress has already appropriated $30 million, equates to only about one percent of the VA's total construction obligations in the last 5 years. If you carry that on into another mathematical or statistical example, it represents about 17 cents for all the veterans' inpatient and outpatient visits that the Veterans Administration will provide over the next 10 years.

We are constantly striving to improve our construction planning program, refine our design programs, and improve our construction procedures. Our mission in the Veterans Administration construction program is to provide timely and efficient and cost-effective management support to the Department's integrated capital facilities program. We take this mission very, very seriously, Mr. Chairman.

We thank you for the opportunity to appear before you today, and we look forward to responding to the questions from you and the members.

I would ask for a bit of indulgence. As you notice, we have a huge amount of books and materials up here. This is sort of a testimony to the size of the VA's construction program. Hopefully, we will be able to answer all your questions, but if you will give us a minute, sometimes we will have to locate the specific facility or project in our book.

Thank you, Mr. Chairman.

[The prepared statement of Susan Livingstone appears at p. 63.]

Dr. ROWLAND OF GEORGIA (Presiding). Thank you. And may I welcome all of you here this morning and tell you how much we appreciate your being here.

Included with the testimony before each Member is a copy of the recent VA assessment of medical facilities. In that document is a listing of each medical center built before 1970 and an estimate of the expected life of the major systems such as heating and air conditioning, things of that nature. This is not an assessment of the quality of care delivered in the facilities, however. It just talks about the——

Mrs. LIVINGSTONE. That's correct, the physical plant condition only.

Dr. ROWLAND OF GEORGIA. I want to focus in on one particular area that Dr. Gronvall and I have already talked about, an outpatient clinic in Savannah, GA. I expressed some concern about that because, as I understand it, the equipment for opening this facility has been delayed because the activation funds have been transferred to other areas, personnel accounts and things of this nature. The clinic was originally scheduled to be opened in June or July. I understand now it may be August before it will be completed.

I would like to ask about these critical shortages of funds and how you go about making the determination about which area will not receive the funds. Can you address that to some extent? How is the determination made that this particular facility will not get funds compared to another one?

Mrs. LIVINGSTONE. Mr. Chairman, I would ask Dr. Gronvall to respond to your question.

Dr. GRONVALL. Thank you very much, Mr. Chairman. Let me describe the general framework for activation of projects during this current year, fiscal year 1989.

When we prepared our budget for 1989 we looked ahead to all of the construction projects that would be completed during 1989, and then did a calculation of the cost in terms of equipment and staffing to activate all those projects. Our estimate of that total additional activation cost for this year was about $258 million. By the time our budget was submitted to the Congress and we received our actual appropriation, as a result of multiple reviews and the general stringency of the Federal budget, our actual appropriation this year for activations was $136,600,000. So we started off the year with an appropriation that was significantly short of our own estimate of the total amount of money needed to activate the projects that would be completed this year.

That has happened to us, unfortunately, in each of the recent years, and the result of that has been to slow activations, introduce some delays, and cause us to relook at the budgets of all the projects and try to activate them with a smaller amount of money than we had originally estimated.

This year we had an additional unique problem, in that the appropriation made this year did not take into account Public Law 100-322, which was passed just last spring. This act has mandatory activities that will cost something like $117 million this year. When our appropriation was made, the Congress wrote into it an invitation to come back to the Congress for supplemental funds to cover that cost and to maintain our full staffing level.

At the beginning of the year we had intensive discussions and reviews with the House Subcommittee on Appropriations and the Senate Subcommittee on Appropriations. We were urged to reallocate a significant amount of additional funds out of the activation budget to maintain our staffing and our operating level at the beginning of the year, and after looking at all of our activations, we did reallocate another $46 million. Therefore, we started the year with an estimate of need of something like $258 million, an appropriation that had $136.6 million, and then, out of that, we reallocated an additional $46 million.

The way we chose to do that was to identify all of the projects that would be completed in the fourth quarter of the year, and then identify those projects as the ones from which we would borrow the $46 million. The Savannah outpatient clinic, the project we discussed recently, is one of those that was scheduled to be completed and activated in the fourth quarter of the year.

The list of projects that have been put into that position of jeopardy actually totals 94 projects. We have projects throughout the entire United States from which we have borrowed internally the equipment funds that are required to activate those projects. Our expectation and hope, of course, is that we will receive supplemental funding from the Congress. If we do, we can restore that money to the activation budgets and proceed. There will still be some delays, and Savannah is one of those that will require some delay and additional funding in 1990. But that's the basis of the decision. In essence, as I said, we took all of the fourth quarter projects and they will be delayed unless we receive supplemental funding.

Dr. ROWLAND OF GEORGIA. All right. My time has expired. You used up all my time, Dr. Gronvall, so I'll have to go to another member. I will come back to this again, though.

Dr. GRONVALL. I apologize, Mr. Chairman, but I felt it was necessary to describe the framework within which that decision was made, because it was not focused only on the Savannah outpatient clinic.

Dr. ROWLAND OF GEORGIA. I appreciate that. Thank you.

The members will be recognized in the order in which they came in. Mrs. Patterson from South Carolina.

Mrs. PATTERSON. Mr. Chairman, I don't have any questions at this time, but I will be submitting some in reference to the facilities in my area.

Dr. ROWLAND OF GEORGIA. All right, without objection.

Tim Johnson from South Dakota was also here and has left.

L.F. Payne from Virginia.

Mr. PAYNE. Mr. Chairman, I don't have any questions, either. I do feel the testimony certainly is very helpful. I will submit some questions after this proceeding.

Dr. ROWLAND OF GEORGIA. I will have to apologize to John Paul Hammerschmidt, the ranking minority member. It is not because I don't like Republicans. I like Republicans very much. I just totally overlooked him and I apologize for that, John Paul.

Mr. HAMMERSCHMIDT. Thank you, Roy.

Dr. Gronvall or Susan, I was going to ask you what major construction project did OMB eliminate in its passback to the VA for fiscal 1990. Are you talking about 94 projects, Dr. Gronvall?

Dr. GRONVALL. No, that's really a different problem. We have 94 projects that will be completed in the fourth quarter of this year, from which we have taken the activation funding and reallocated those funds to support current operations. That's quite a different problem than the OMB——

Mr. HAMMERSCHMIDT. Okay. Could you give us that list, or is it too extensive to give now?

Mrs. LIVINGSTONE. No, sir. I can very briefly list the projects. These were major construction projects which we requested funding for from OMB in the fiscal 1990 budget, but they were not in the budget that was submitted to the Hill.

Mr. HAMMERSCHMIDT. If you would.

Mrs. LIVINGSTONE. The projects are a nursing home in Lake City, FL; another renovation for a nursing home in Salisbury, NC; a clinical improvements and patient privacy project in Nashville, TN; a laundry replacement in Knoxville, IA; a bed addition in Temple, TX; a spinal cord injury center and canteen project in Salt Lake City, UT; a clinical addition at Wilmington, DE; design funds for a clinical bed addition in Reno, NV; construction funds for the first phase of the Detroit Medical Center; a 290-bed psychiatric facility for Gainesville, FL where we were requesting design funds for that; and three regional offices for colocation located at Cleveland, OH, Hartford, CT, and Montgomery, AL. I will provide additional information for the record.

Mr. HAMMERSCHMIDT. Did the VA appeal any of those?

Mrs. LIVINGSTONE. Yes, sir, we did.

Mr. HAMMERSCHMIDT. Which ones did you appeal?

Mrs. LIVINGSTONE. Perhaps Mr. Neumann has a list of the specific ones that we appealed.

Mr. HAMMERSCHMIDT. And also give us the results, Mr. Neumann, please, if any.

[The information appears at p. 69.]

Mr. HAMMERSCHMIDT. Let me ask you, did you win any of those appeals?

Mrs. LIVINGSTONE. Yes, sir, some of the appeals were won. Our initial submission to OMB in terms of the 1990 budget request was about $770 million total—that's major and minor construction. The initial result back from the Executive Branch deliberations provided a budget of about $459 million. Then we appealed a level back up to about $563 million, and the end result was the budget provided to Congress at the $487.6 million level.

Mr. HAMMERSCHMIDT. So you actually got about $486 million?

Mrs. LIVINGSTONE. Yes, $487.6.

Mr. HAMMERSCHMIDT. One more specific question. Why did the VA eliminate the 30-bed spinal cord injury unit for Gainesville in September of 1988 and instead put 20 spinal cord beds at Tampa? How long will this delay the availability of beds? If the shift was a result of changing MEDIPP data, which is hardly ever, just when does the VA take the snapshot necessary to decide to move ahead with the project?

Mrs. Livingstone. Mr. Hammerschmidt, I would ask Dr. Gronvall to respond to that question. That was a deliberation that was made through the DM&S planning process. Initially, those beds were part of a 120-bed nursing home care unit and a 30-bed spinal cord injury unit, as a joint project scheduled at Gainesville. Based on planning decisions, the Department determined that those SCI beds should be transferred to Tampa, increasing that project at Tampa to 100 spinal cord injury beds, and leaving Gainesville with the 120-bed nursing home care project.

In terms of the specifics of the planning decisions, I would ask Dr. Gronvall to respond.

Dr. Gronvall. Dr. Lewis has the information.

Dr. Lewis. The feeling, Mr. Congressman, based on regional planning decisions was that emphasis should be given to concentrating SCI beds at Tampa due to the increased demand in that area and due to construction phasing problems.

Mr. Hammerschmidt. I understand that the optimal size the VA originally approved was 60 beds, and then they got it up to 100 beds; is that correct?

Dr. Lewis. At Tampa, yes, sir.

Mrs. Livingstone. The initial planning I believe at one point was for 100 beds at Tampa, and then there was a decision potentially to split the spinal cord injury beds between Tampa and Gainesville. Now there has been a restoration back up to 100 beds at Tampa. That's my understanding of the planning process decisions.

Mr. Hammerschmidt. Well, the red light is on now, but if you want to expand on that for the record, we would appreciate that very much, to see exactly how you came to your determination.

Dr. Gronvall. I think that's a good request, Mr. Hammerschmidt, because we can define in writing all of the factors that were taken into account as we looked at both Tampa and Gainesville. That was not an easy decision. But we would be pleased to supply the details for the record.

Mr. Hammerschmidt. We would appreciate it very much. Thank you.

(Subsequently, the Veterans Administration furnished the following information:)

The history of our SCI planning efforts in Florida dates back several years to the activation of the 41 bed SCI unit at Tampa in 1971. Until 1983, a project had been in process to expand SCI capabilities at Tampa. In early 1983, a decision was made to combine the SCI project with a clinical addition project at Tampa in order to provide needed clinical support services in one project. The project, however, continued to be delayed because of other agency-wide construction priorities. Problems were also encountered in acquiring necessary land for expansion. These land purchase difficulties, including legal proceedings relative to obtaining clear property titles, continued until purchase of a tract of land in 1985.

Throughout this time period the planned scope for expansion at Tampa varied with consideration given to activating SCI units at both Gainesville and Bay Pines. This was in response to a PVA request in late 1984. In early 1985, a decision was made to site 80 beds at Tampa and to also activate a new 30 bed SCI unit in Gainesville. This was a change to our previous plans to site a 100 bed SCI unit at Tampa and appeared to offer the advantage of having the SCI beds more geographically dispersed. In early 1988, we re-examined this strategy, as reflected in the 1988 Strategic MEDIPP Plan, and determined that returning to our original planned expansion of 100 SCI beds at Tampa would provide the service in an area where the largest population of SCI veterans currently resides. This change was also supported by the action that the Tampa VA Medical Center has taken since 1985 in converting hospital beds to bring their SCI operating beds to a current level of 70. This action was necessary, as an interim measure, to keep pace with the growing demand for SCI care in the Tampa area. The above, coupled with Tampa's role as one of the VA's few designated Comprehensive Rehabilitation Centers influenced our decision.

The project is presently scheduled for design in FY 1991 and construction in FY 1992.

Dr. ROWLAND OF GEORGIA. Thank you, Mr. Hammerschmidt.

Mr. Rowland of Connecticut.

Mr. ROWLAND OF CONNECTICUT. Thank you, Mr. Chairman.

It appears the order of the day is to take care of parochial concerns first, and I will follow that schedule.

First, I would like to thank those testifying. I see in Connecticut we have funding for construction of a major replacement and modernization project in Newington, and I'm very pleased to see that. I would like to pose a question to Dr. Gronvall, if I may.

We have discussed construction funds for a clinical addition in West Havan. My understanding is that its in the 5-year plan. I would like to inquire as to whether there is money available for the engineering fund, the architectural work that has to be done. Perhaps Mrs. Livingstone would respond to that.

Mrs. LIVINGSTONE. Mr. Rowland, that project has been approved for advanced planning, so advanced planning funds are available for it. That basically brings it up to the preliminary design stage, which then enables us to provide an estimate for budget purposes. That project is currently scheduled as a future project in fiscal 1993.

Mr. ROWLAND OF CONNECTICUT. So, in other words, the architectural funds are in place?

Mrs. LIVINGSTONE. That is corect for the advanced planning portion. Basically, we're changing our design process, but to keep it simple, we now have a three-step design process. We do conceptual development, then a preliminary design that gives us a budget estimate, and that is followed by what we call a working drawing design. The project is currently funded for conceptual development and preliminary design.

Mr. ROWLAND OF CONNECTICUT. Would you give me some kind of a time frame on that?

Mrs. LIVINGSTONE. Currently, the project is scheduled for fiscal 1993 budget consideration. In terms of the advanced planning, I'm not sure the architect-engineering firm, which would be a firm out of Connecticut, has been hired as yet. But again, we would have to have completion of preliminary designs by September of 1991. That would be our target date for getting it in the 1993 budget.

Mr. NEARY. If I could expand on that for a minute, sir, the West Haven facility has been identified as one of the first facilities to have a facility development plan completed. The Regional Director in the Northeast Region has recognized the needs of the West Haven facility, and we have begun that effort.

We have had our contractor on site, working with the medical center, and we would expect to have completed the facility development plan in the late summer of this year and then have a much clearer picture of the direction we will take in terms of facility corrections. We will then move into the design process that Mrs. Livingstone just spoke of.

(Subsequently, the Veterans Administration furnished the following additional information:)

VAMC WEST HAVEN, CT—CLINICAL IMPROVEMENTS/RESEARCH AND EDUCATION UPGRADE—PROJECT No. 689-029

This project, which is planned for funding in FY 1993 and is currently estimated to cost $16,300,000, proposes to correct deficiencies in ambulatory care, laboratory, outpatient pharmacy, research and surgery services. New construction will be housed in a multi-story structure proposed to be located between the two main medical buildings. Significant renovation will take place within departments located on the lower floors of the existing buildings.

The ultimate scope, funding and scheduling of this project will be determined by a variety of factors including: the availability of funding resources, the priority score of the project compared to the national ranking, the approved medical center mission, the approved bed level and projected work loads. Many of these factors will not be known until sometime in the future.

Discussions have taken place between DM&S, the Regional Office and the VAMCs Newington and West Haven on the relocation of the surgery program from VAMC Newington to West Haven. The results of these discussions may alter or increase the current cost and scope of the proposed major project.

This VAMC is the "lead" station for the Medical Region I, Group I, FY 1987 FDP contract. The joint venture of Cannon New York Architecture and Engineering PC/Coopers & Lybrand, Inc., is currently working on the first stage of the FDP at West Haven.

Once the scope of the project has been determined, the A/E firm of Stecker LeBau Arneill Architects, Inc. of Hartford, CT, has been selected to provide preliminary planning services.

Mr. ROWLAND OF CONNECTICUT. Thank you.

Mrs. LIVINGSTONE. This is what we're calling the lead facility in that particular region for completion of a facility development plan. That plan again just provides a major assessment of the current and projected future physical and functional deficiencies at that medical center and the best way to get them corrected for the best price possible.

Mr. ROWLAND OF CONNECTICUT. If I can follow up on the discussion of the FDP's, Mrs. Livingstone, you made reference to the funding support by the Congress, the system and how it's working. My understanding is that that started back in January of 1987 with the pilot program in four VA medical centers.

First of all, I would applaud you because I think it's the proper way to go, and most people would agree. I think there is some general concern among other organizations that perhaps it may be overkill. In other words, perhaps there's too much information being gathered and it's perhaps too costly.

We have appropriated about $30 million for the program, and I think this budget adds about another $10 million.

Mrs. LIVINGSTONE. That's correct.

Mr. ROWLAND OF CONNECTICUT. Which obviously would add up to $40 million, to survey all 172 medical centers.

Do you feel that this is enough and that this estimate is correct, or do you anticipate the FDP program costing more in the future?

Mrs. LIVINGSTONE. Mr. Rowland, we do not anticipate the FDP costing any more in the future. When we first embarked on this endeavor, we used funds in the fiscal 1987 budget. At that time we were deliberating on what the cost estimate would be. We estimated—and this was back in late 1985—that the estimated cost per facility development plan, similar to what we would be doing at West Haven, was about $250,000.

Currently, our estimate, based on the results of the pilots, and also some initial inputs from the contractors we've hired for the first 80 facility development plans, we believe the range—and this is average, nationwide, once the effort is completed—would be about $280,000 to $300,000.

Some medical centers that are large and complex, and have numerous buildings, will cost more. Smaller ones will cost less. Those, of course, that had recent modernization projects would cost less. But we still estimate it will be $280,000 to $300,000. That's basically an inflation adjustment. We believe $40 million will be what is required to complete the effort.

Mr. ROWLAND OF CONNECTICUT. There has been some criticism about the volume of information and the irrelevant information that has been gathered.

Do you suspect that you'll be able to tighten up—I make reference to one of the veterans' organizations that talks about the pilot project in Indiana. The study is some 1,900 pages long and goes into talking about the plants and the fertilizer and on and on.

In light of the tough financial times that we're facing, we have concerns that perhaps the expenditure will be much more than $40 million and that once the contracts go out, there won't be much control after the fact. I know there was a study done, a report done.

Do you anticipate tightening up to assure that we don't expend more money than we have to?

Mrs. LIVINGSTONE. Mr. Rowland, the concerns expressed were based on an assessment or review of one or perhaps several of the pilot projects. The pilot projects were undertaken just as that, as pilot projects, in an effort for us to test out various approaches, various procedures, best ways of doing things, to learn from the process, and then finalize on the best approach to take. The comments and concerns I believe are reflective perhaps of some of the items or actions that some of the veteran service organizations observed in the pilot processes. As a result, from the pilots, we did exactly what we intended to do. We learned a lot from them. We reduced the amount of data that has been gathered from those. The time frame will be significantly reduced.

Again, we allowed the pilot contractors sort of a free hand and free rein to explore different ways and approaches and methodologies and to proceed in different ways so we could learn from the process.

We feel this is a significant, critical, crucial effort for the VA's construction program. Quite frankly, in justifying resources and budget requests in scarce budget environments, the people who have got the hard data and the documented justifications are the people who are going to do the best. We feel that we need that in the construction program. We've got a good planning system, but it's not one that is really as comprehensive or as sophisticated as this one is going to be.

The data that is being generated or requested out of the FDP process reflects data that different elements within the Veterans Administration feel they need. Some of those could be architects, some could be engineers, some will be health care planners, some will be facility planners, some will be doctors, some will be chiefs of staff, et cetera. Basically, the length of this document is reflective, for the first time ever, of bringing all this data together in one integrated document, where it is all interrelated and justifies an end result.

In terms of the Marion, IN FDP, I haven't counted the pages, but if that's about 1,900 pages—it's my understanding that in the revised format that the new facility development plans will be about 800 pages. I'm not sure what page size is a reflection of, particularly. We don't want to hold it down artificially to where it can't exceed a particular page size or whatever.

I think the real concern that the VSO's may be expressing by that comment is are we doing too much data, and our answer to that is no, we feel we're doing it correctly.

Mr. ROWLAND OF CONNECTICUT. I would agree with you, that the number of pages is not important, and I don't want to embarrass anybody, but there are some irrelevant, I think, amounts of information that are added in. But I have full confidence that the VA will monitor the program and make sure that we're not throwing money away. I have confidence that that won't happen.

Thank you.

Mrs. LIVINGSTONE. Mr. Rowland, I might also say we would be pleased, if there are any specific data that you've seen that you feel are unnecessary, we would be pleased to respond to you on why that data is being collected.

In point of fact, because it's reviewed from a pilot, it could be that one of those data elements has been eliminated.

Mr. ROWLAND OF CONNECTICUT. Thank you very much.

Thank you, Mr. Chairman.

Dr. ROWLAND OF GEORGIA. Thank you.

Mr. Harris.

Mr. HARRIS. Thank you, Mr. Chairman.

I have a couple of questions. One—and you can provide this later—I would like to know the plan that you have for projects in my State of Alabama in the next 5 years, and specifically whether or not you're familiar with a new proposal that the University of Alabama has made to work with the VA hospital in Tuscaloosa. It's the aquifer thermal energy storage research for heating and air-conditioning systems.

Are you familiar with that?

Mrs. LIVINGSTONE. Mr. Harris, I'm not familiar with that. I might ask Dr. Gronvall if that's been brought to their attention.

Dr. GRONVALL. No. I have no knowledge of it.

Mr. NEUMANN. We don't either.

Mr. HARRIS. Well, it's new technology for heating and air conditioning. As I understand it, the university has proposed to work with the VA there to help put the system in. It has a projected 50-percent savings on the cost of heating and air conditioning.

Dr. GRONVALL. I would just say, Mr. Harris, that across the country we encourage our local medical center managers to enter into those kinds of creative discussions, either with university hospitals or Department of Defense health care facilities.

Mr. HARRIS. Dr. Blair is on board there. I would ask from this end of the line, also, for any support you can give to it. I think it's a worthwhile project. There might be something that can be developed nationwide if we can save that kind of money.

Dr. **Gronvall**. We appreciate your calling it to our attention. Typically, what happens is those discussions go on locally. When it gets to a point where the local people believe it is a totally feasible project, they will recommend it to us. That's the point in which we hear about it. So I appreciate the alert, and we will look into it. We are surely anxious to find anything we can that improves our energy efficiency.

Mr. **Neumann**. Mr. Harris, I would be interested on technical grounds. I know our staff would be.

Mr. **Harris**. I will provide you with what information I have. Thank you very much. There are several other industries that have already done that.

(Subsequently, the Veterans Administration furnished the following information:)

UTILIZATION OF UNDERGROUND AQUIFERS FOR ENERGY CONSERVATION AT VAMC TUSCALOOSA, ALABAMA

This facility is in the preliminary design stage of development of a Major Construction Project No. 679–068, Renovate Building 38/New 270 Bed Psychiatric Building.

The facility was aware of an experimental project at the University of Alabama utilizing underground aquifers to provide "free cooling" for one of their buildings. They believed that there would be a significant potential to utilize a similar system for their facility and as such requested inclusion of studies on this idea as part of the preliminary design.

Dr. Brandt, a professor at the University of Alabama, is one of the foremost experts in utilization of aquifers for cooling and is at present developing a proposal to act as a consultant to the A&E if the use of aquifers is shown to be viable.

Ground water aquifers in that part of the country can provide water at a temperature of 55 to 60 degrees Fahrenheit which can provide a significant amount of the cooling required and a smaller portion of the heating required. This type of system appears to offer a good potential to help reduce the energy consumption and costs with the VA during certain times of the year. However, the temperature of the water is not low enough to dehumidify outdoor air and provide complete cooling.

How many nursing home beds are planning to be opened in 1990 for the southern region?

Dr. **Gronvall**. I don't have the breakdown for the southern region. If you wanted that projection just for that region, we would have to supply that for the record. I have national data.

Mr. **Harris**. If you would do that, I would appreciate it.

(Subsequently, the Veterans Administration furnished the following information:)

There will be an additional 100 new nursing home beds available in 1990 in the Southeastern Region as a result of planned activations in the mid to latter part of Fiscal Year 1989. The new beds are attributable to 72 additional beds at VAMC Murfreesboro as part of their construction project and 28 additional beds will be converted to nursing home beds at VAMC Biloxi.

Mr. **Harris**. I notice that one of the projects you mentioned that was disapproved by OMB was the combining of the regional office in Montgomery. That was approved the last time but disapproved in the appropriations process in the House. But this time it didn't even make the first cut.

Mrs. **Livingstone**. That's correct, Mr. Harris. The Veterans Administration did request funds in the fiscal 1989 budget for it. It was cut during the congressional appropriations process.

Mr. Harris. It passed this committee.

Mrs. Livingstone. Yes. We submitted it again to the Office of Management and Budget in fiscal 1990 for funding, and just based on the constrained resources facing the construction program, it was not funded. It was not a reflection on OMB's support or nonsupport for colocation. They are very strongly supportive of colocation. It just was a matter of budget resources in fiscal 1990.

Mr. Neumann. It was appealed.

Mr. Harris. That's when I heard it, when you read off the list.

Actually, there were three of them proposed. Were any of them approved?

Mrs. Livingstone. No, sir. All three were eliminated. Montgomery was the number one priority, however, in the Department of Veterans Benefits for those colocation projects.

Mr. Harris. Thank you, Mr. Chairman.

Dr. Rowland of Georgia. Thank you, Mr. Harris.

Chris Smith of New Jersey has asked that a statement be made part of the record. Without objection, so ordered.

[The statement of Hon. Chris Smith appears at p. 76.]

Dr. Rowland of Georgia. Mr. Kennedy.

Mr. Kennedy. Thank you very much, Dr. Rowland.

Dr. Gronvall, first of all, I would like to thank you for having approved the trip up to Boston to check out our VA outpatient clinic in the city. As you're aware, that clinic still is in terrible shape. The elevators are still falling down, the air and water pressure is almost nonexistent, the dentists are still refusing to go into the building, the exposed wiring still exists, the asbestos still exists, and so on down the line.

Smith Jenkins, who is the administrator of the clinic, has indicated that a plan will be completed in about a week and forwarded to the VA Central Office. I'm just hopeful that you will actually move on this issue at this time to be able to do something about the outrageous conditions. I think even General Turnage called them atrocious when he was informed of what was going on up there. I just wonder whether or not you have some response in terms of an actual plan to deal with the clinic.

Dr. Gronvall. Yes, Mr. Kennedy. I would agree with the way you characterized that building. It is a terrible facility. I don't want to sound offensive, but it is not a facility that the VA owns and operates.

Mr. Kennedy. You've been in it for how many years, sir?

Dr. Gronvall. We've been in it for many years——

Mr. Kennedy. About 40 years.

Dr. Gronvall (Continuing). And it has progressively deteriorated, and the current conditions are really abysmal. We believe that in the long run we need to be in new space that the VA will have responsibility for. We think the current situation is so bad that we need to relocate to some temporary space while we're completing longer term plans. We surely have that as a very high priority. We are working on it concurrently and hope to be out of there as soon as we absolutely can.

Mr. Kennedy. Right. I hear all the words and adjectives, and they're all what I want to hear. On the other hand, the difficulty is, as you're well aware, this problem has gone on now for years and years. There are 20,000 veterans out there who are not being well served, which I think you recognize.

The question is whether or not we can actually come up with a plan to get the thing either temporarily housed or however you want to handle it.

Mrs. LIVINGSTONE. Mr. Kennedy, I think, as Dr. Gronvall has indicated, we share your urgency and also the priority. That building is not a building that is appropriate for veterans to enter, nor for the VA to be in.

Mr. KENNEDY. I've got all the right adjectives. What's the plan?

Mrs. LIVINGSTONE. Basically, as soon as the plan is formulated for the space requirements, we hope to be able to leave as quickly——

Mr. KENNEDY. Well, when is the plan going to be formulated on space requirements?

Mrs. LIVINGSTONE. They're in the process, I believe, of developing that now.

Mr. KENNEDY. I don't want to hear "they're in the process." I have heard too many words like that this morning already. I want to hear where the plan is in terms of actually—I mean, you knew that I was going to ask these questions this morning. It just seems to me that we've strung these people along an awfully long time. We have got to at some stage actually come up with a specific plan that says when they are going to—Could you submit that in writing to my office?

Mrs. LIVINGSTONE. I would be delighted to get it to you tomorrow, Mr. Kennedy. But let me just ask Mr. Maurer if he knows the specifics on when we might be able to have a final plan to get a lease authorization for the temporary move.

Mr. MAURER. We don't have a specific date established for lease authorization at this point because we're still waiting for the facility there to submit their temporary reduction plan. As we discussed yesterday with your folks, our interim plan entails a reduction in space over the short term to get out of the abysmal building.

Mr. KENNEDY. I think, Dr. Gronvall, you can kind of pick up the frustration that I feel. I hear this not just from constituents of mine, but Joe Moakley's office has been in touch with me, and we have actually gone over and talked about some of these problems and the like.

I appreciate the dilemma you're in. You're waiting for the Boston office to come back and to come up with a plan. He can't give you the plan until he gets the plan from—and nothing happens. So what I'm trying to get at, at some point it's incumbent upon the Administrator to set the fellows straight and get the job done. You know, we can hide behind the bureaucratic slowdowns, but the fact is that people aren't being served.

I just appeal to you, Doc, to please intervene in this one and get those people helped out. It's a terrible situation.

Mr. HAMMERSCHMIDT. Joe, would you yield?

Mr. KENNEDY. Sure.

Mr. HAMMERSCHMIDT. I think the VA, in a number of instances in these outpatient situations, is involved in GSA-leased property, which I gather this is. They have that problem in New York and in St. Petersburg, with really bad quarters. So it's kind of a GSA program. I don't want to borrow trouble, but the General Services Administration comes before our Public Works and Transportation Subcommittee, and that might be another place to approach this problem and expedite and help the VA do it. I would be pleased to try to be helpful in that area, if it's appropriate.

Mr. KENNEDY. Thank you very much, Mr. Hammerschmidt.

I think the reality of this situation is that the building is in such terrible condition that everybody is in agreement that the building has got to be shut down. In fact, the building inspectors refused to go into the building the other day. So I think it has gone perhaps beyond the GSA problem. GSA has a problem with this building.

Mr. HAMMERSCHMIDT. I think it is their problem, really.

Mr. KENNEDY. Yes, sir, but it's also the veterans problem. I think the VA has been forward looking enough to recognize that they've got to get out of the building. Now I'm just trying to goose them along to get them actually into another building so that they can actually serve those veterans.

Mrs. LIVINGSTONE. Mr. Kennedy, if I might, we have been working with GSA over the years, trying to get building corrections, et cetera. It's been basically a very fruitless and frustrating process. The decision now is to just "fish or cut bait" and get out as quickly as possible. But that was a recently made decision.

The outpatient clinic has to reduce its square footage by about 30,000 square feet for us to afford it within the $2 million available, and they have to develop a plan on how they're going to cut back to that space. We'll try to get a sense from them today about how long that will take, and they can then provide the space plans to us, and then we'll develop a paper and get that up to you tomorrow.

Mr. KENNEDY. That would be great. If you could have specific dates on that, in which you're going to hold one of these bureaucratic entities to, that would be terrific.

Thank you very much.

Could I just take one more minute, Mr. Chairman, to ask——

Dr. ROWLAND OF GEORGIA. Sure.

Mr. KENNEDY. Claude Harris brought up an issue that I actually worked on before coming to Congress, to set up a number of different companies to deal with the energy management needs specifically of hospitals throughout the country. I actually formed a nonprofit organization that would go in and provide millions of dollars worth of investments to hospitals in exchange for the hospital agreeing to just simply pay its traditional energy bill. Actually, they get a reduction in those energy bills each year for a period of 10 years. At the end of the 10 years, they get around a 40 to 50-percent reduction in their total fuel bill.

I wonder whether or not the VA has actually looked into contracts like that and has actually entered into those contracts, because you can save millions and millions of dollars and get lots of money pumped back into the building.

It is also a way, if you are not able to get money out of the Government to go back into the facility for hardware, it's a way to use the dollars saved in energy bills to actually go back into the building in terms of hardware. That was one of the things we used to do, to take asbestos out of school buildings and the like, when the cities and towns couldn't come up with the money themselves. So I just think it's a way to save some money and get some efficiencies.

Mrs. LIVINGSTONE. Indeed, we have a very active energy conservation program. In fact, we have gotten awards for it last year from the Department of Energy. In particular, we have been replacing a number of our energy monitoring devices with very sophisticated computerized energy management systems.

Mr. KENNEDY. Everybody does that from time to time on their budgets. I am wondering if you've ever put contracts out for bid and let independent agents come in and make bids to bring your energy bill down?

Mrs. LIVINGSTONE. We attempted that. In fact, we were required by law to undertake a pilot test of a shared energy program where we would do just that. We would put out our solicitations and share the savings, whatever they came up with, et cetera. We put the bid out and no one responded because VA's energy program was so effective they didn't feel they could generate great savings. So we had no responses to the solicitation.

Mr. KENNEDY. Was it in a particular facility?

Mrs. LIVINGSTONE. Yes, at Perry Point, MD.

Mr. KENNEDY. Maybe you had taken your top energy-efficient building. But I'll tell you, you put that Boston building in, I guarantee, I know one company that will bid on it. I'm just suggesting that maybe if you take your most efficient building and put it out there, you're not going to find a lot of people who want to bid.

Mr. NEUMANN. We didn't do that. We took a facility, a pre-World War II facility, at Perry Point, MD.

Mr. KENNEDY. Well, if you could maybe tell me what you have done in terms of a little report on it, I can get it to our people and take a look and see what you've done.

Thank you very much.

[The material referred to above appears on p. 71].

Dr. ROWLAND OF GEORGIA. Mr. Ridge.

Mr. RIDGE. Would the proposed limitation on outside income prevent my friend and colleague from bidding on that job?

[Laughter.]

Mr. KENNEDY. We were nonprofit.

Mr. RIDGE. Okay. I was just curious.

I really applaud the VA's effort with regard to the FDP. I know you did a CFS on 132 facilities built before 1970, and now we're doing the FDP's, and I guess a lot of members have some C-O-N-C-E-R-N-S about this.

[Laughter.]

I would like to share a couple of them with you and maybe get some responses.

First of all, the CFS studies show that about 12 percent of the 132 medical facilities built before 1970 were either poor or failing. I am curious as to whether or not these structures are given the highest priorities as you let contracts under the FDP program.

Mrs. LIVINGSTONE. Mr. Ridge, in terms of those specific facilities, they would be given high priorities if there were also functional deficiencies present. The CFS was purely a physical plant assessment, just the state of the physical plant. The Department of Medicine and Surgery picked the groups of the facility development plans to be funded in the order of funding availability, based on a functional assessment of deficiencies within the system, not just the physical plant condition. For instance, a deficiency in surgery, or a deficiency in some type of patient privacy issue were strong considerations in the selection of the FDP sites.

Mr. RIDGE. So it also included a quality-of-care component?

Mrs. LIVINGSTONE. Yes, in terms of the determinations of which projects should be funded first.

Mr. RIDGE. And the FDP is taking a narrower view and appropriately looking just at the facility itself, to see if it's up to code, the wiring, the plumbing, the physical plant itself?

Mrs. LIVINGSTONE. The capital facilities studies did the physical plant condition. We're using that, if you would, as an input into the facility development plan, which is both functional and physical.

Mr. RIDGE. I guess I'm a little bit concerned at the estimate that you can accomplish this all for $40 million. I guess I'm equally concerned that the money is being well spent or appropriately spent, given the nature of the information you're trying to glean from each facility.

I have seen the reports on the Marion facility, and you stack them up and there are three volumes. While I don't normally like to do this, I am going to read an excerpt from the section on existing vegetation.

"The majority of existing large trees are deciduous, mature in size, and large enough to create bold and dramatic forms that assist with smaller plants in bringing the expansive structures down to a human scale."

Does anybody in the VA, first of all, know what "deciduous" means?

Dr. GRONVALL. I guess it's trees that drop their leaves every year during the winter.

Mr. RIDGE. Right. But the point is, it seems to me that we've got somebody going out to these facilities, spending a lot of money, telling us what the landscape should or could look like. The point is, we're looking for $40 million to find more pharmacists, nurses and whatever. I just want you to know that I think what you're doing is right, it's forward-looking, and it's appropriate. But I'm not sure that we have to expend $40 million to do it.

I guess I wonder why we do not have an in-house capability within the VA, since we run and administer and maintain these facilities, why we would have to go out and contract in 172 different communities, with 172 different consulting engineers and architects, why this was not undertaken internally.

Mrs. LIVINGSTONE. Mr. Ridge, if I could respond to your question in two parts, in terms of the deciduous trees and the landscaping comments, obviously the contractor was taking poetic license——

Mr. RIDGE. I've got to tell you, this is just—it's not germane, anyway.

Mrs. LIVINGSTONE. What they are required to do is take a look at site considerations which would be needed, either for the preparation of an environmental assessment, should there be any construction action taken; or to assist in terms of the actual location or fronting of a building, things of that nature. Obviously, in this particular case, the contractor involved became more eloquent than was necessary.

Mr. RIDGE. I understand that the VA has promulgated some guidelines for the FDP's, basically a "how to" book, and the "how to" for the FDP's is about 700 pages long.

Mrs. LIVINGSTONE. The "how to" book is about 400 pages long, I believe, of which the vast majority——

Mr. RIDGE. I don't want to get into a quantity——

Mrs. LIVINGSTONE. I know. Basically, we had four pilot tests of the facility development planning process. The purpose of that was to learn from that process and to glean the best from it. We used a style guide as a manner of advising our contractors that we were hiring what we expected in terms of level of detail, quality, what we wanted each of their sections to look like, and to make sure it was consistently formatted in style and substance.

In the actual style guide itself, the instructions are quite short. What most of the style guide contains are actual examples, so that these contractors know what it is that's expected from them. We needed that both to get the end result and also negotiate fees with them.

In terms of doing it externally by contractor, we did not have the in-house resources to devote to this effort. We have a planning staff that's really devoted to a lot of ongoing project planning and not available to go nationwide to 172 medical centers in order to undertake this type of effort. What we are doing, however, is consolidating these plans by region. For instance, in the first grouping, we're doing 40 of them divided by seven contractors, so we're not paying for these contractors to relearn the process. As they learn they can move through the other regional facility development plans on a more expeditious basis.

Mr. RIDGE. Let me tell you again, I think it's wise and prudent that you're conducting these studies now. I think it's very forward-looking. I just hope that, given the expense incurred in the pilot programs, and your anticipated cost of $40 million, that you don't go a dime over it. Because it seems, as you look at some of the expenses incurred previously, your ability to keep within that $40 million cost is going to test you and those who oversee the bids and negotiations with these contractors. I want to encourage you to stay within that $40 million cost.

I have several other questions related to some interest in the VA facility in Erie, PA and in Pittsburgh, PA, as well as some follow-up questions on the FDP program and some of their priorities. I would ask unanimous consent that I be given the opportunity to submit them in writing.

Dr. ROWLAND OF GEORGIA. Without objection.

Mr. RIDGE. Thank you.

Dr. ROWLAND OF GEORGIA. Mr. Hammerschmidt.

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

I want to just briefly get into a subject that I know is of interest to our new ranking member of the full committee, Mr. Stump, so let me ask a couple of questions relative to that.

Which new nursing homes have no funds for staffing and equipment and thus can't be opened upon completion?

Mrs. **Livingstone**. I would ask Dr. Gronvall to respond to that. The actual listing is one which he was referencing among these 94 projects, for which an activation funding shortfall is being experienced.

Dr. **Gronvall**. Mr. Hammerschmidt, I have the list of the 94 projects that I referred to earlier, where there will be activation problems in the fourth quarter of this year. It would take me a few minutes to go through that list and pick out the nursing home projects.

Mr. **Hammerschmidt**. Well, don't go through that long list. Just put it in the record, please.

Dr. **Gronvall**. I could supply that for the record.

(Subsequently, the Veterans Administration furnished the following information:)

VA NURSING HOME CARE UNITS WHOSE ACTIVATION WILL BE DEFERRED DUE TO FOURTH QUARTER FUNDING PROBLEMS

Facility	Project No.	No. of Beds
Alburquerque, NM	501101	47
Durham, NC	558023	120
Lyons, NJ	604064	240
Philadelphia, PA	642C34	240
Prescot, AZ	649047	60
Syracuse, NY	670032	30

Mr. **Hammerschmidt**. Let me ask you about one specifically that certainly is of interest to Mr. Stump.

When will the new Prescott VA nursing home in Arizona be completed and when will it open its doors to veterans? Can you give us a response to that?

Mrs. **Livingstone**. The Prescott nursing home is one of those listed in this group of 94 for potential delayed activation. I would ask that Mr. Neumann give you the estimated completion date. Currently it's scheduled for activation in the fourth quarter of fiscal 1989, and based on the Department's assessment, that is one of those projects that would be potentially delayed in activation as a result of lack of funding.

Mr. **Hammerschmidt**. The fourth quarter of '89 is the short answer.

Mr. **Neumann**. The current completion date is around the end of April of this year.

Dr. **Gronvall**. And we have it in our budget as requiring some $600,000 worth of equipment to be installed before it can be activated.

Mr. **Hammerschmidt**. Thank you very much.

Mr. Chairman, there is a number of other questions here that I want to submit to the VA for their written response, and I know we have other witnesses waiting to testify, so I won't pursue the questions verbally any further.

Thank you very much.

Dr. **Rowland of Georgia**. Okay. Without objection, those will be submitted, Mr. Hammerschmidt.

Dr. **Rowland of Georgia**. I have two or three things I want to ask about. We talked about the sequence of events in the construction budget request to some extent, but let me ask you this, Mrs. Livingstone.

What were the major and minor dollar requests to the Administrator from the Office of Facilities for fiscal year 1990?

Mrs. **Livingstone**. The actual request from the Office of Facilities to the VA Administrator?

Dr. **Rowland of Georgia**. Correct.

Mrs. **Livingstone**. For the major construction projects, the request was $635.5 million.

Dr. **Rowland of Georgia**. Major and minor?

Mrs. **Livingstone**. That's major.

Dr. **Rowland of Georgia**. Well, I have a figure here of about $960 million, major and minor.

Mrs. **Livingstone**. The initial request was $811.6 million, of which $635.6 million was for major, $149.1 million was for minor, and $26.9 million was for parking.

Dr. **Rowland of Georgia**. For a total——

Mrs. **Livingstone**. The total was $811.6 million. That was the initial request from the Office of Facilities to the Administrator.

Dr. **Rowland of Georgia**. The VA submission to OMB was how much?

Mrs. **Livingstone**. The actual submission then from the Veterans Administration to OMB was $769.8 million.

Dr. **Rowland of Georgia**. That's a pretty significant reduction. What is the difference between those two figures?

Mrs. **Livingstone**. There were a number of projects where it was determined not to put them in the actual OMB request. Mr. Neumann has a listing of those projects, and as we indicated previously, we would be glad to submit those for the record. Basically, there were a number of different deliberations. There was an initial list of projects proposed, those which did not make it over to OMB, and then those that did not receive funding in terms of the 1990 budget request pending before Congress. We can provide that list of projects in the sequence in which those appeals occurred.

(Subsequently, the Veterans Administration furnished the following information:)

PROJECTS INCLUDED IN THE VA'S INTERNAL REQUEST BUT NOT INCLUDED IN THE OMB REQUEST

The following projects were included in the VA's internal major appropriation request but were not included in the OMB request:

Dallas, TX—Clinical Addition, Renovate Building 2, and Spinal Cord Injury Center (Design)
East Central Florida—New Medical Center (Land Acquisition)
Mt. Home, TN—120 Bed Nursing Home Care Unit
Marion, IL—Clinical/Outpatient Addition and Ward Construction
Marion, IN—Geropsychiatric Facility
Line Item for Claims Analysts

Funding was provided in the FY 1989 appropriation for the Dallas and Mt. Home projects. The East Central Florida, Marion, IL, and Marion, IN, projects were determined to require further development prior to inclusion in a budget submission. Claims analysts were included as a part of the minor appropriation, general administration request.

Dr. ROWLAND OF GEORGIA. How does that compare with the OMB target?

Mrs. LIVINGSTONE. The original OMB construction target for fiscal year 1990, as reflected last year in the congressional fiscal 1989 budget submission, was $705.6 million. As the fiscal 1990 budget request is $487.6 million, that's a reduction of about $218 million over what the OMB planning target was for this fiscal year.

Dr. ROWLAND OF GEORGIA. Let me ask you something else, Dr. Gronvall.

There are no nursing home beds included in the FY 1990 budget; is that correct?

Dr. GRONVALL. Well, there are no new free-standing nursing homes planned in 1990.

Dr. ROWLAND OF GEORGIA. Why is that?

Dr. GRONVALL. Our requests to include nursing home projects were not approved by OMB.

Dr. ROWLAND OF GEORGIA. It looks like OMB is continuing to be a problem.

What outpatient facilities, Mrs. Livingstone, are scheduled for construction in the fiscal year 1990 budget?

Mrs. LIVINGSTONE. In terms of actual planned awards in fiscal year 1990, awards for clinics in fiscal year 1990 would be in Bakersfield, CA, the Quad Cities, which is the Iowa/Illinois area, San Jose, CA, and Tallahassee, FL. Those are the current new outpatient clinics that we're targeting for award in fiscal 1990. We also have a number of awards planned for fiscal 1989, this current fiscal year.

Dr. ROWLAND OF GEORGIA. I want to go back to the Savannah clinic for a couple of questions.

That is to be a leased facility, as I understand it. I understand there is a rather complicated formula for making the determination as to whether or not the Veterans Administration will construct the facility or whether or not it will be constructed by a private concern and leased to the Veterans Administration; is that correct?

Mrs. LIVINGSTONE. I would say it's less complicated than it used to be. We are required to comply with the provisions of OMB Circular A-104, which is basically a formula for conducting economic cost analyses to assist in making decisions between leasing, purchasing, or building these new facilities. That is now a computerized program called TAPS. It is used Government-wide, and that has greatly simplified the process in terms of actually doing the output. The complicated part is getting the inputs, which is all the market data, things of that nature. That's what takes time.

Dr. ROWLAND OF GEORGIA. Listening to Mr. Kennedy earlier, and to Mr. Hammerschmidt, talking about the sad shape in some of the buildings that are leased, is there some requirement for keeping the buildings up and is that a function of GSA or the Veterans Administration to oversee that?

Mrs. LIVINGSTONE. Mr. Chairman, in Veterans Administration leased outpatient clinics, we don't have that problem. We set our standards and we keep them very high and maintain them. In May of 1983, GSA delegated authority to the VA to lease its own outpatient clinic space, and we have been doing it since then. Boston predates that period for lease and, quite frankly, GSA, I'm sure, has been suffering from deferred maintenance funding over the years. That's beginning to get reflected in a number of facilities around the country in terms of Federal buildings that are operated by GSA.

We have worked with them. In the Boston situation, we have actually brought in our own engineers to do a physical plant assessment, trying to build our case that we needed improvements in the maintenance and fire safety issues in the building. GSA initially didn't have the funding and I think at this point has probably determined that the building is in such sad shape that it's not worth repair. So I think they will be just as glad to have us depart from the building as we will be glad to depart from the building.

Dr. ROWLAND OF GEORGIA. Does the responsibility for the upkeep of the building belong to GSA or the lessor of the building.

Mrs. LIVINGSTONE. In this case, I believe it's a federally-owned building and it would be GSA who would be responsible for the maintenance. GSA also leases from lessors, in which case the lessor usually is responsible for maintenance. In the case of Boston, that is a GSA-owned building and they are responsible for the maintenance.

Dr. GRONVALL. I think, Mr. Chairman, as Mrs. Livingstone says, that is quite a different situation. When we're in a Federal building managed by GSA, we have to deal through GSA with problems about the building. I think that's very complex.

If a contractor has a direct lease with the Veterans Administration, we know who's running the building and can deal directly with the contractor who is running the building, and I think have a better record of ensuring that the building is maintained.

Dr. ROWLAND OF GEORGIA. I just want to ask one other question, but I have some other questions that we will want to submit for the record. I want to go back to the Savannah clinic again, which will be completed maybe in August.

I believe you said that the decision to look for funds was based on when the facilities would be ready, and that was the last quarter?

Dr. GRONVALL. Correct.

Dr. ROWLAND OF GEORGIA. Well, the Savannah clinic is not being completed in the last quarter; it's being completed in the third quarter, I believe, in August?

Dr. GRONVALL. The most recent information we have is that it will be completed in August, and that is the last quarter of this year. Our fiscal year ends in September, so that falls into the last quarter of the year.

Mrs. LIVINGSTONE. Mr. Rowland, if I might, I have been advised that the lessor, the person who is actually providing that clinic to us, has recently been granted an extension. He asked for a 45-day, kind of no-cost extension, to help deliver the space, so the actual completion date might be late August and could even be rolling over into September at this point.

Dr. ROWLAND OF GEORGIA. I see. So the VA will not have to pay rent on that until 45 days later, is that it?

Mrs. LIVINGSTONE. We begin paying rent as soon as we accept the building. In this case, with late August or early September, we may not accept the building until some time in September, possibly even early October, at which point we're in a new fiscal year and hopefully the Department's activation funds would be available to help activate that clinic. We're not talking about a large delay here.

Dr. ROWLAND OF GEORGIA. Thank you all very much for being here this morning.

Mrs. LIVINGSTONE. Thank you.

Dr. ROWLAND OF GEORGIA. The next panel is Mr. Daniel Swedberg, who is a senior associate with Booz, Allen & Hamilton, accompanied by Ms. Elizabeth Gray, who is an associate.

We have a Member coming over, Mr. Bilbray, and we may have to interrupt your testimony here when he comes. So, until he does, I will ask you to proceed in your own manner, Mr. Swedberg. Thank you both very much for being here this morning.

STATEMENT OF DANIEL I. SWEDBERG, SENIOR ASSOCIATE, BOOZ, ALLEN & HAMILTON, INC.; ACCOMPANIED BY ELIZABETH GRAY, ASSOCIATE

Mr. SWEDBERG. Thank you for inviting us. We are pleased to appear before you today to discuss the results of our evaluation of the four facility development plans. The pilot plans were developed in Marion, IN, Marion, IL, Long Beach, CA, and Northport, NY.

Booz, Allen's evaluation of the pilot FDP's was started in April, 1988. It was conducted in two phases. The first phase was limited to the initial stage of the FDP process, and the second phase focused on the overall process.

The first phase of the study was completed in August, 1988, and we are currently awaiting the VA's review of our overall evaluation report. My comments today are based on conclusions and recommendations contained in that overall report.

Our conclusion from the evaluation is that the pilot phase of the FDP implementation has been a success. To understand that conclusion, it may be helpful to begin by explaining that the pilot FDP's were intended to accomplish two primary goals: first was to demonstrate a feasible approach to meeting objectives established for facility development plans in the 1985 VA construction study that served as the impetus for this initiative; the second goal was to provide a way to identify and resolve problems related to cost effectiveness before further implementation of the process.

Our findings from the evaluation demonstrate that both of these goals were accomplished by the pilots.

The 1985 VA construction study defined three objectives for FDP's. They were intended to provide information needed to, first of all, develop construction project plans; secondly, prioritize and justify 5-year facility construction plans; and finally, coordinate current and future construction actions at the facility.

Based on a review of the four pilot facility development plans and interviews with over 100 people who were either involved in or knowledgeable of the results of the pilot FDP's, we found that all four pilot FDP's accomplished their intended objectives. In other words, we found that the pilot approach represents a feasible way to accomplish objectives originally established for facility development plans.

We also examined cost-effectiveness issues encountered in preparing the four pilot FDP's. Our primary purpose was to identify weaknesses in the pilot process and to determine if steps had been taken by the VA to resolve them in planning for full-scale implementation. A number of weaknesses were identified that reduced the efficiency of the pilot process and the quality of the results received. However, we also identified actions that have been taken by the VA since the beginning of the pilots to address those weaknesses. Those actions include numerous refinements to the facility development plan statement of task, explicit definitions of the responsibilities of various VA organizations involved in the process, preparation of guidance on standard FDP format, and a number of other actions.

As a result, the process the VA is now using for full-scale implementation is significantly improved from the process used to prepare the pilot FDP's. Therefore, the pilot implementation was successful in identifying and resolving issues related to cost effectiveness, the second primary goal of the pilots.

Because of this, we recommend that the VA continue with full-scale preparation of FDP's at remaining VA medical centers. We believe the VA's goal should be to complete FDP's at remaining medical centers over the next 3-year period. Our report identifies two refinements, in addition to those already implemented by the VA, that should be considered for implementation in the full-scale FDP process.

In addition, we recommend that the VA focus attention on other aspects of the FDP program that will determine its ultimate success in the years to come. One of those is the development of procedures and systems for updating and revising FDP's on an ongoing basis. The ongoing maintenance of FDP's is an important issue for the future viability of the program.

Another issue that should be addressed is the impact of FDP's on VA's national construction planning. The 1985 VA construction study identified opportunities for improvement in national construction planning that could also be achieved once FDP's are completed. We believe that the VA should begin now to determine the requirements of an integrated database that uses FDP data to improve national construction planning. Their goal should be to complete those improvements within the next 3-year period.

In summary, we believe that the VA is on the right path for making significant improvements in planning for its health care facilities. The preparation of facility development plans at VA medical centers is an important first step in providing information needed to ensure that construction dollars are spent wisely in the VA.

Thank you.

[The prepared statement of Daniel I. Swedberg appears at p. 77.]

Dr. **Rowland of Georgia**. Thank you, Mr. Swedberg.

Mr. Hammerschmidt?

Mr. **Hammerschmidt**. Thank you very much, Mr. Swedberg.

Where were those four pilot projects?

Mr. SWEDBERG. They were located in Marion, IL, Marion, IN, Northport, New York, and Long Beach, CA.

Mr. HAMMERSCHMIDT. In your statement you say, "Our report identifies two refinements, in addition to those already implemented by the Veterans Administration, that should be considered for implementation in the full-scale FDP process." What are those two refinements?

Mr. SWEDBERG. One of the refinements is to identify roles for Central Office oversight of the process, specifically providing roles for review for the Office of Strategic Planning and the Office of Architecture and Engineering.

The second refinement is to make some additional changes to guidance provided for carrying out the process. One example of that is the guidance provided for using MEDIPP data. We are suggesting that MEDIPP data should be used as a maximum number rather than a specific point estimate in planning for future VA functional needs.

Mr. HAMMERSCHMIDT. Do you know how much the VA paid Booz, Allen for this study?

Mr. SWEDBERG. I believe it's somewhere on the order of $200,000.

Mr. HAMMERSCHMIDT. If that's not correct, would you supply the correct figure for the record?

Mr. SWEDBERG. Sure.

Mr. HAMMERSCHMIDT. Thank you very much, Mr. Swedberg.

Thank you, Mr. Chairman.

Dr. ROWLAND OF GEORGIA. Thank you, Mr. Hammerschmidt.

I have a couple of questions I would like to ask. There is one criticism of the facility development plan, that it is a "bottom up" rather than a "top down" process. How do you answer that criticism?

Mr. SWEDBERG. During the time that we were carrying out the evaluation, we noticed that there were two basic ways to implement the FDP program. I think some of the concerns that have been raised have to do with that issue.

The way that the VA has chosen to implement the program is, as you have said, with a bottom up approach—focusing on the most critical aspect of the program, the development of the individual plans—first. Another potential way to implement the program is through a top down approach, doing a complete design of the entire program, and only after that design is completed, to begin implementing.

We looked at both approaches and believe that the VA's approach is a sound approach—in fact, it's the best approach for the situation. What they are doing is achieving benefits from the program immediately by getting FDP's in place. We think it's a logical way to go about implementing the program.

Dr. ROWLAND OF GEORGIA. There is another criticism, that the plan is very costly compared to the original estimates based on pilot projects.

Mr. SWEDBERG. The original estimate, as Mrs. Livingstone was saying earlier, was $250,000 for each facility development plan. I believe the average was higher for the pilots, somewhere in the order of $300,000 to $350,000.

Once again, these are pilot facility development plans that have been developed. The pilots had objectives other than to develop plans. The objectives were to test a new approach, to identify weaknesses in this approach. These other factors caused the price of the pilots to be higher than what would be expected in the full-scale process.

As I said, we looked at potential improvements in the efficiency of the process that the VA has been implementing over the last few months, and we believe they're going to have a major, positive effect on the efficiency of the process in the future.

Dr. ROWLAND OF GEORGIA. One final question about the plan. It has been said it includes far too much information to be flexible and easily responsive to changes in veteran demographics and VA needs. Is that a just criticism?

Mr. SWEDBERG. I don't believe so. I believe that the data that is included is important data. I think one of the distinctions that has not been well made so far is the distinction between the data that's contained in the working papers involved in developing the FDP and the FDP itself. The FDP itself is a much smaller document. There is a great deal of documentation that is developed to get to that point.

The VA is making a very logical decision to organize those working papers so that they can prepare for the future when they attempt to develop an integrated database for national construction planning. I think the approach they are taking is a wise approach.

Dr. ROWLAND OF GEORGIA. Thank you very much. We have no further questions.

Mr. SWEDBERG. Thank you.

Dr. ROWLAND OF GEORGIA. Mr. Bilbray, we're pleased to have you here this morning.

STATEMENT OF HON. JAMES H. BILBRAY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEVADA

Mr. BILBRAY. Thank you, Mr. Chairman.

Mr. Chairman, I want to thank you for allowing me to testify before the subcommittee today on your review of the Veterans Administration construction budget for hospitals and nursing homes.

As this committee has seen, thousands of veterans across the country are being turned away from adequate health care. The Veterans Administration in recent months has begun to terminate health care programs and take hospital beds out of service and to deny to certain groups of veterans care at virtually every veterans hospital in the country. This alarming trend will surely get worse as we see a medical budget shortfall over the next 2 years of $1.1 billion below the amount needed to deliver the level of health care service provided in fiscal year 1988.

Mr. Chairman, currently Nevada veterans who need inpatient care must turn to the nearest VA hospitals, which are in Loma Linda, CA, about 350 miles away, and the southern Nevada veterans, which make up the bulk of the veterans in my State, have to go to Reno, which is about 400 miles away.

The absence of a local veterans hospital has been a hardship for many of the more than 100,000 veterans in southern Nevada. In

1988, the VA outpatient clinic in Las Vegas, which does not provide hospital care, referred to transferred to the VA hospital in Southern California 1,882 patients. All the indications are that this problem will only grow.

Southern Nevada has become a favorite retirement community and developers have on the drawing boards new communities which are designated to attract more new seniors, many of whom will be veterans. In fact, my district has 5,000 people a month moving into the district at the present time.

As in many cases, families of veterans are unable to get to Southern California to visit their loved ones. That has been both a financial toll of traveling and an emotional toll of being away during a traumatic time in a family's life.

Since 1982, then Representative Harry Reid, now the senior Senator from Nevada, has been working on getting support for a joint Veterans Administration/Department of Defense hospital to be built at Nellis Air Force Base. Recently scheduled for fiscal year 1989, the Department of Defense moved the start-up date to fiscal year 1991. Through much hard work and persistence, that date has been moved back to fiscal year 1990. In the budget submitted to Congress on January 9, the Air Force requested $62 million for its share of the cost. The VA was asked for $9.3 million, for a total of $71.3 million. Of the 128 beds, 52 will be allocated for veterans and 76 to the Department of Defense.

This hospital is to be operated as a truly integrated facility. No separate wards are provided for DOD or veteran patients. With the average short-term veteran inpatient staying just over 13 days, the health needs of up to 2,000 veterans can be reasonably provided each year out of this facility.

In a world without massive Federal deficits, I would probably be asking the committee to consider building a separate facility for southern Nevada veterans and active duty military personnel and their dependents. We do have a massive Federal deficit and the funds are simply not available to build two hospitals. This joint effort is a creative way of dealing with the health needs of veterans and future veterans.

My conversations with people at Nellis and in the veterans community indicate to me that there is a willingness to make this joint solution work. Mr. Chairman, in the past 2 years I was fortunate to work with the local veterans and Nevada state officials to create a state veterans cemetery in southern Nevada. In a speech before a joint session of the Nevada legislature, I spoke of the veterans who got very little pay and gave up years of their lives for their country. All they are asking for is what is rightfully theirs. We must never forget them. I urge the subcommittee's support for the VA hospital at Nellis.

Thank you.

[The prepared statement of Congressman Bilbray appears at p. 80.]

Dr. ROWLAND OF GEORGIA. Thank you, Mr. Bilbray. I really appreciate your coming this morning and giving us this testimony.

Mr. Hammerschmidt, do you have any questions or comments?

Mr. HAMMERSCHMIDT. Well, I want to thank our colleague for his testimony. It's kind of an interesting thing to have the first fully integrated hospital like this in your district. It makes a lot of sense. I don't know which would manage that. I haven't discussed it with anybody. I'm assuming the Air Force would——

Mr. BILBRAY. The Air Force would manage it, as I understand. I think it's a solution because you have military people that sometimes have an overcrowding situation, and there will be less veterans; other times you may have some veterans that overflow it. It will balance it. The Air Force needs the extra beds, the veterans need the beds, and I think it will be an economical way of running it. It may be something to look at in other areas.

Mr. HAMMERSCHMIDT. We're glad to have it in the 1990 budget for design.

Mr. BILBRAY. Thank you.

Dr. ROWLAND OF GEORGIA. There is some real good sharing that is going on between the VA and the military. We looked at several different facilities around the country and some really good activity is going on in that area.

Thank you very much for being here this morning.

Mr. BILBRAY. Thank you.

Dr. ROWLAND OF GEORGIA. The next panel is Mr. Noel Woosley, national service director of AMVETS; Col. Herb Rosenbleeth, national legislative director of the Jewish War Veterans of the United States; and Mr. Robert Manhan, special assistant, National Legislative Service, Veterans of Foreign Wars.

Gentlemen, thank you very much for being here this morning. Mr. Woosley, we will ask you to begin, if you will.

STATEMENTS OF NOEL C. WOOSLEY, AMVETS NATIONAL SERVICE DIRECTOR; COL. HERB ROSENBLEETH, U.S. ARMY (RET), NATIONAL LEGISLATIVE DIRECTOR, JEWISH WAR VETERANS OF THE UNITED STATES OF AMERICA; AND ROBERT MANHAN, SPECIAL ASSISTANT, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

STATEMENT OF NOEL C. WOOSLEY

Mr. WOOSLEY. Thank you.

Mr. Chairman, members of the committee, AMVETS thanks you for this opportunity to testify with respect to the administration's proposed FY 1990 construction budget for the Veterans Administration, soon to be known as the Department of Veterans Affairs.

At the outset, let me state that we find the administration's proposed budget as pertains to construction not only inadequate but unrealistic. We base this on the fact that as the aging process of America's veterans continues to be spotlighted as a primary concern, there is little, if any, evidence that this same aging process is of any concern with respect to VA facilities.

In the area of new construction, the proposed three new outpatient clinics would appear to contradict the current medical methodology of outpatient treatment in order to obviate the need for hospitalization. While the need for outpatient clinics will vary greatly based on the demographics of an ever-changing veteran population, it is not at all difficult to target several states where the presence of an increased number of outpatient clinics may be the only way the VA will be able to keep the promise.

To illustrate, estimates of the veteran population of the United States and Puerto Rico are 27,359,000. Seventy-eight percent of all living veterans had wartime service but, moreover, the report shows that nearly half of all living veterans are located in just eight States, those States being California, New York, Texas, Pennsylvania, Florida, Ohio, Illinois and Michigan. It should be noted that in California a major conversion project of 117 nursing home care beds was just recently canceled by the VA.

With the projected two new nursing homes and the conversion of hospital beds to nursing home care beds, the administration's proposed budget shows an increase of 1,035 in the nursing home care beds census for FY 1990. At the same time, this budget proposes to cut VA domiciliary beds of 3,475 from the FY 1989 census. Granted, domiciliary beds are not nursing home beds, but they would seem to appear to be easily converted, and these are also used to maintain the medically indigent.

There is also a proposed loss of 3,449 in the community nursing home bed census. This would, in fact, appear to be a loss of 5,889 potential nursing home care bed census, during a time when all the studies point to an ever-increasing need for these facilities.

Once again to illustrate, there is currently 1.1 million veterans 75 years of age or older. There are 126,000 World War I veterans, with a median age of 91, and 9,606,000 World War II veterans, with a median age of 66.

The adoption of the administration's budget as proposed would set the entire VA medical delivery system on a rapid course to extinction and those proponents of privatization would be the eventual winners.

As you are aware, Mr. Chairman, AMVETS, the Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars have once again cooperated in an effort to address the needs of America's veterans based on moral as well as legal obligations this Nation has deemed as just and befitting those men and women who chose to answer duty's call. Thus, for the third consecutive year, we have produced an independent budget by veterans, for veterans. With the knowledge that each member of this committee has a copy of the proposed independent budget, I should like to point out that for the purpose of this hearing, we totally support the construction program principles and guidelines as outlined in said document.

We feel that the recommendations, strategies and overall development in respect to the VA's minimum construction needs are factually based and realistically spelled out. We respectfully request that each member of this committee review the independent budget and give careful consideration to the proposed funding levels contained therein.

Thank you again, Mr. Chairman. This concludes my statement.

[The prepared statement of Noel C. Woosley appears at p. 83.]

Dr. ROWLAND OF GEORGIA. Thank you, Mr. Woosley.

Colonel Rosenbleeth.

STATEMENT OF HERB ROSENBLEETH

Colonel Rosenbleeth. Chairman Montgomery and members of this subcommittee, I am Herb Rosenbleeth, the National Legislative Director of the Jewish War Veterans. On behalf of our membership,.I thank you for the opportunity to appear today to testify before this distinguished committee.

Since its founding in 1896, the Jewish War Veterans of the USA, the oldest active veterans' organization in the United States, has stood for a strong national defense and for just recognition and compensation for veterans. JWV is a voice for America's security interests around the world and it has always been a supporter of human rights issues.

I want to comment on Mr. Kennedy's remarks about things being "in the process", and add that I was thinking the same when he said it. I'm going to conclude my remarks by further elaborating on the VA/DOD health care resources sharing program, and I'm going to suggest that that, too, has been "in the process" or potentially delayed perhaps too long. But first I would like to go through some other prepared remarks.

Mr. Chairman, the JWV strongly believes that the VA needs to update and repair many, if not most, of its medical centers. Electrical, heating and plumbing systems and equipment are in dire need of modernization throughout the VA health care system.

The VA needs to construct at least four new 120-bed nursing homes each year and convert current VA hospital beds to nursing home beds on a programmed basis. The estimated cost of four nursing homes is $30 million per year, and the cost of converting an adequate number of VA hospital beds is approximately $20 million per year. The VA needs to speed up construction projects, reducing the time from initial planning of projects to their completion.

JWV concurs with the fiscal year 1990 request for $112 million for the building of a new VA facility at Palm Beach, FL and with the $53.7 million for modernization of the VA medical center in Newington, CN. It must be noted—in fact, emphasized—that the proposed facility in Palm Beach is the first medical center to be added to the VA system since the mid-1970s, and that the Florida area has an urgent need for many more VA beds. JWV also concurs in the $10.7 million request for the renovation of certain buildings at the VA medical center in Lyons, NJ, and the $6 million in design funds requested for the seismic project at the VA medical center in Long Beach, CA.

In a climate of ever-increasing health care costs, and an expanding Federal budget deficit, the Congress has instituted measures to ensure close cooperation between the Veterans Administration and the Department of Defense in all new health care facilities construction.

As you know, Public Law 97-174 is the keystone legislation which supports a wide range of health resources sharing between the VA and DOD. More specific legislation to encourage VA/DOD joint venture hospital construction soon followed. Public Law 99-579 directed the Administrator of the VA to "give consideration to sharing with the DOD the cost of any new construction, alteration or acquisition of a medical facility which involves a total expenditure of more than $2 million." Further, the military construction appropriation act, fiscal year '87–88, directed that the DOD will not proceed with design of new hospitals in the U.S. until all possibilities of shared use with the Veterans Administration are fully explored.

Currently, there are six joint ventures between the VA and DOD involving construction in various stages of development. I have listed those in my statement and will not elaborate on each one individually, except to say that you previously heard about Nellis Air Force Base, and I have listed that along with five others and would reiterate the comments of the speaker on Nellis. This is a tremendous opportunity for DOD and VA.

In addition to the six that I have cited, the VA and DOD are exploring the potential for other joint venture projects in East Central Florida, Spokane, WA, Philadelphia, PA, and Lubbock, TX.

In view of the pressure of the Federal deficit, and the enormous expense of medical facility construction and maintenance, JWV urges the VA to strengthen its participation in the health care resources sharing program with DOD. And I emphasize to strengthen that participation. I really feel the hierarchy at the VA has not aggressively pursued these opportunities.

I do, however, on behalf of JWV, wish to commend the members of the VA Central Office at the lower levels who have been managing this important program and have done, in my opinion, their best to make it work.

Jewish War Veterans appreciates being able to appear before this subcommittee on this extremely important legislative issue. We are grateful to you, Mr. Chairman, and to this subcommittee for your efforts in support of America's veterans.

[The statement of Herb Rosenbleeth appears at p. 87.]

Dr. ROWLAND OF GEORGIA. Thank you very much, Colonel.

Mr. Manhan.

STATEMENT OF ROBERT MANHAN

Mr. MANHAN. Thank you very much, Mr. Chairman. I am Bob Manhan from the Veterans of Foreign Wars.

At our recently held national convention, our 2,200,000 members showed a great deal of concern about the lack of moneys available in the Veterans Administration construction budget that would be dedicated primarily to VA's owned and operated nursing home health care facilities. Rather than to repeat extracts of the testimony that I have already provided, I would like to address a separate Government report that reinforces many of the points that the several veterans service organizations have made in their independent budget regarding nursing home care facilities. I am referring to the General Accounting Office's November, 1988 transition report No. 14. The long title is "Veterans Affairs Issues."

Although this pamphlet is only 20 pages long, about 5 pages are dedicated to the challenge regarding serving veterans' long-term care needs. The report points out—and I'm quoting now—that "The VA has three alternatives: one, facilities it owns and operates; two, private community facilities with which it contracts; and third, veterans' homes operated by States." The remaining four pages discuss some of the major shortfalls if one were to use option 2, community facilities, or option 3, veterans homes operated by States. I'm going to quote selectively.

The report says, "Many factors affect the availability of community nursing home beds. Although high nationwide, nursing home occupancy rates vary substantially from place to place. In some areas, it may not be realistic to expect that VA can gain access to additional private sector capacity, whereas other areas may have plenty of room. Regional variation in nursing home vacancy rates needs to be taken into consideration in the VA's planning." It further states that "The VA may not get access to new beds because of disincentives for community nursing home operators to accept VA-supported patients. These disincentives include administrative burdens and VA length-of-stay limitations."

Then they go on to further discuss the last alternative. Several factors also hinder the expansion of beds in State veterans homes. It includes the availability of Federal and State funding to construct and expand them, and the length of time required to develop, approve and fund individual projects. While the VA can fund up to 65 percent of the cost of a State home, States must approve funding for a project before the VA can request Federal matching funds. As we all recall, approximately 20 States have never taken the initiative or shown the interest to fund for State veteran nursing homes.

In sum, Mr. Chairman, I believe that this independent report further amplifies the very significant need for moneys to be made available to the Veterans Administration, to start this coming fiscal year 1990, to develop and construct and/or convert selective space for nursing home care facilities.

My concluding remark is to apologize for my own error on the second page of my testimony. In the second paragraph I erroneously referred to this fiscal year's VA construction budget of $501 million. We all know that for next year, fiscal year 1990, the year under discussion, it is approximately $488 million. Again, I hope I haven't caused anyone too much inconvenience.

This concludes my remarks. Thank you, Mr. Chairman.

[The prepared statement of Robert Manhan appears at p. 89.]

Dr. Rowland of Georgia. Thank you very much.

Mr. Manhan, I want to commend you and Mr. Woosley, your organizations, for the role that you've taken in preparing this independent budget for the VA. It is that kind of cooperation and expertise that is really essential in keepng our VA system going.

Colonel Rosenbleeth, I am pleased that you talked about the VA/DOD sharing in your testimony. I think that's very important. We have had the opportunity, as I mentioned earlier, to look at some of these facilities where that has taken place. It seems to be working real well.

I am advised that in 1984 there were 102 agreements, and in 1988 there were 307 agreement. You've already mentioned the proposed hospital joint ventures that are going on now. So I feel real good about those things.

Let me ask all of you this. Would your members be willing to write letters and otherwise support the call for more nursing home care beds that you mentioned in your testimony?

Mr. Woosley. I don't think you would have any problem in that area.

Colonel Rosenbleeth. Absolutely.

Dr. Rowland of Georgia. Okay. Thank you.

Mr. Roland.

Mr. Rowland of Connecticut. Thank you, Mr. Chairman. I, too, would like to commend all of you for the hard work that you have put into your own budget.

I would merely inquire: with the independent budget that you've worked on, the numbers that have been given on construction costs and the dollars that you would like to see appropriated, do those reflect the numbers in your independent budget, Mr. Manhan? Is that appropriate?

Mr. Manhan. Would you repeat the question, please?

Mr. Rowland of Connecticut. Let me restate the question.

I have not looked at your independent budget, and I don't think that most of the members have yet. The numbers that you make reference to in your testimony, are those reflected in your independent budget?

Mr. Manhan. Yes, they are.

Mr. Rowland of Connecticut. Could you give me a "Readers Digest" version of the independent budget, the total dollars? You mentioned in your comments, if we used more leadership and create thinking and so forth and so on, we could get more bang for our buck. Would you expand upon that a little bit?

Mr. Manhan. Yes. To try to support that philosophic phrase, it can mean trying to work perhaps more closely with the VA to look at the priorities again. It would be wonderful if they had all of the assets to do everything they would like to do. But just with the testimony we have heard here today, we should refocus some efforts, change some priorities, based on the immediate needs.

For example, using a nautical term, some of these problems were once over the horizon. Older veterans today are on the horizon. Of course, with time, it's only going to get worse. I use that only to reinforce the nursing home care issue.

Mr. Rowland of Connecticut. In the financial crisis that we're facing, where would you say the VA has been deficient in setting priorities and where are there instances where they are spending too much money or an inappropriate amount of money or priorities?

Mr. Manhan. Thank you very much. On behalf of the VFW, I don't think I could point out a single instance where the VA is wasting money. I would suggest that, given the VA's very critical national strategic mission, they have not had the appropriate amounts of money historically to do things that should have been done in the past, when it was maybe cheaper. Today, to repair or hold together an aging physical plant that can have some strategic importance, is very, very expensive. Perhaps it paints the VA in a position of looking historically to be somewhat inattentive to their own business. But I suggest that it's a lack of money, historically.

Mr. Rowland of Connecticut. Not to catch you off guard, but generally, would you be supportive of a concept of, in regions, finding VA medical centers close to each other, and supporting the concept of perhaps specializing, rather than all the VA medical centers trying to be all things to all veterans, specializing in a nursing home facility in one instance, specializing in a surgical facility in another instance?

I make that comment because in Connecticut we are walking through that process. We have two VA centers that are about 35 miles apart, and we're coming to the logical conclusion that we can't provide all the services with the shortage of dollars and do it well.

Does the VFW have a position? Have they thought this out? Is this a possibility across the country?

Mr. MANHAN. Thank you very much, Mr. Rowland. That's an excellent question. I have never really heard it posed that way. Therefore, I don't believe the VFW, as an organization, could possibly have prepared a response, but I will give you my own immediate reaction to that.

Where certain, very unique types of hospitalization and/or facilities are required—I would use a spinal cord injury clinic, for example—those perhaps should be located strategically where the greatest preponderance of veterans live. Those other types of medical facilities that deal with the more common illnesses and ailments of most veterans, then I think there should be nationwide facilities.

I had implied, if not clearly stated, in the VFW testimony that we look upon the VA facility, the medical plant, as a strategic, national asset. Therefore, I would be very hesitant to start to have only a very few specialized facilities across the 48 States, the lower 48. Then what would we do about Alaska and Hawaii, the Commonwealth of Puerto Rico and, of course, the Republic of the Philippines?

I hope I have given you as good a philosophic answer as possible. But the question was excellent.

Mr. ROWLAND OF CONNECTICUT. I pose that question, and would pose it to all the veterans organizations here. In your testimony you make reference to applying some creative thinking and some intelligent leadership within the veterans community. I think these are some of the creative ideas we're going to have to explore.

I would challenge the veterans organizations here to explore some of those ideas, to see if they will work, and if we can provide the best care and service to our veterans with these tough financial times. I appreciate all of your testimony.

Dr. ROWLAND OF GEORGIA. Thank you very much, gentlemen.

The fourth and last panel is Mr. Gordon Mansfield, associate executive director for government relations, PVA; Mr. Samuel Walsh, assistant director, National Legislative Commission, the American Legion, who will be accompanied by Mr. Richard Christian, deputy director of the National Veterans Affairs and Rehabilitation Commission.

Gentlemen, thank you for being here. Mr. Mansfield, we'll ask you to lead off.

STATEMENTS OF GORDON H. MANSFIELD, ASSOCIATE EXECUTIVE DIRECTOR FOR GOVERNMENT RELATIONS, PARALYZED VETERANS OF AMERICA; SAMUEL J. WALSH, ASSISTANT DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION, ACCOMPANIED BY RICHARD CHRISTIAN, DEPUTY DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

STATEMENT OF GORDON H. MANSFIELD

Mr. MANSFIELD. Thanks, Mr. Chairman.

The first thing I would like to do is ask that the testimony that's been prepared be submitted for the record. I would like to comment on just a few of the highlights.

Dr. ROWLAND OF GEORGIA. Without objection.

Mr. MANSFIELD. I would like to start by saying I come here both confused and amazed. I would like to start on the issue of FDP's. Having been here throughout the morning and listening to the excellent questions from the members, and the testimony and the answers given from this table previously, I thought that a lot of the questions we had addressed in our testimony were answered.

However, I was amazed at the testimony presented by Booz, Allen & Hamilton, especially in the conclusion. I would like to refer to the fact that they bring up two recommendations. Number one is the development of procedures and systems for updating and revising FDP's on an ongoing basis. I think what I've heard then is we have spent—and I think if you go with the revised figure of $300,000—somewhere around $50 million. What I'm hearing is there is no plan for updating this or revising the information received.

Even of more concern—and I'll quote—"another issue that should be addressed is the impact of FDP's on VA national construction planning." That's where I got amazed. I thought this whole system was set up so we would wind up with a national planning system; so that some kind of logical formulation could be developed, so that the limited dollars could be spent in the best way. As I say, I'm amazed that the testimony of the experts that studied the FDP process come up with those two questions. I thought these issues should have been addressed when they started this plan. I would suggest that the committee might want to ask the VA how much more is it going to cost to accomplish those two recommendations made by the experts.

The next concern is more specific to the organization of paralyzed veterans, SCI construction. This is where I get confused.

We've been through a process and we thought we had SCI units that were needed planned for. We have shown the demand, the demographics are there, PVA has worked with the VA to establish what the number of patients going in and out of these facilities is.

One example is Dallas, TX. My understanding is we've spent $2 million in design funds. Out of nowhere we find a 59-percent increase in MEDIPP data that says stop it in its tracks and let's start over. My problem there is very parochial. There is an SCI unit tied up down there. I wonder, in times of tight budgets, can we be affording $2 million already spent and just throw it out the door and forget about it.

The other concern is the continuing problem of Tampa, FL and Gainsville, FL. I have had two answers already on this. PVA talked to the folks in DM&S and talked to the folks in the Office of Facilities. We had a meeting with the regional director, who had a DM&S representative and an OF representative present. The question was, why are you canceling Gainsville? The answer was, we don't have an answer available, but we'll supply one.

The letter to PVA pointed out that the MEDIPP data for 1988, the first time this data was used in SCI construction, indicated there should be a change. I refer to our testimony, and the attached letter of Dr. Gronvall to Chairman Montgomery, which I think was sent in September, in reference to a May decision on the budget last year. It doesn't indicate MEDIPP is the answer. I look forward to the reply that Dr. Gronvall will submit to the previous questions.

I would point out, too, my understanding is that $250,000 of design funds on the SCI unit will probably be wasted. I also wonder how they're going to put two stories of another type of care unit, nursing home, that were designed to be the second and third floors when you don't have the first floor there when you cancel the SCI unit. They're going to have to go back and redesign the whole thing.

I think also part of the problem is evidenced in the situation we have out in San Diego, CA, where we had a dedication just before the end of the last fiscal year of a new SCI unit. Our latest information indicates that possibly there will be ten beds opened this March. So again, all I can say, sir, I come here amazed and confused, and I'm looking for answers. I hope we get some in the replies for the record.

Thank you.

[The prepared statement of Gordon Mansfield appears at p. 92.]

Dr. ROWLAND OF GEORGIA. I appreciate you focusing on the update of the FDP's. We'll submit a question to the VA and ask them to answer that for us.

Mr. Walsh.

Mr. WALSH. Yes, sir. Thank you very much.

This morning I have with me Mr. Dick Christian, who recently joined our staff as Deputy Director of the National Veterans Affairs and Rehabilitation Commission. He will present our testimony.

Dr. ROWLAND OF GEORGIA. Okay. Thank you.

STATEMENT OF RICHARD CHRISTIAN

Mr. CHRISTIAN. Mr. Chairman, the American Legion is pleased to appear before the subcommittee today to present its views on the present and future status of the VA medical construction budget.

Before addressing the issue under consideration today, we would like to state for the record that the American Legion was greatly pleased at the enactment of the Department of Veterans Affairs Act in October, 1988. This satisfied a long-sought goal we had been pursuing for over two decades.

May we say at the outset that the American Legion is an ardent supporter of a medical construction program that is adequate to the needs of all veterans.

While the original mission remains, the VA medical system must also evolve to meet the particular health care needs of an aging veteran population. Available 1988 figures indicated that there are 9.1 million veterans 65 years of age and older, of which approximately 1.2 million are over the age of 75. There are an additional 5.8 million veterans between the ages of 50 and 59. In addition, the VA medical care system has been designated by the Congress as a contingency resource for the armed forces in the event of a future conflict or natural disaster.

In order for the Department of Medicine and Surgery to keep pace with such developments and to ensure quality medical care is being provided, it would be reasonable to conclude that, in view of the age of many VA hospitals, after a 25 to 30 year period or more, major renovation or replacement would be needed.

The provision of acute medical services has changed from a concept of total in-house case to an added emphasis on outpatient ambulatory care.

The fiscal year 1990 budget proposal of $487.6 million reflects an overall decrease of approximately $13 million in construction funding from the current fiscal year. The fiscal year 1990 budget proposal addresses needed facility replacement and modernization by assigning $183 million for that purpose. This figure represents a $41 million increase from the preceding year. Funding for other major improvements which was not identified was increased by $26.9 million.

We note, however, reductions in certain construction categories from the preceding year. The fiscal year 1990 budget reflects a loss of $41.5 million in nursing home care, $32 million in domiciliaries, $18.9 million in the parking garage revolving fund, and $58 million in environmental improvements in patient and nursing home care buildings.

The bottom line is that the overall fiscal year 1990 budget proposes funding that is lower than in each of the preceding 3 fiscal years. We do not believe the physical plant of the VA can ever be considered sufficiently funded when annual appropriations for renovation and replacement are declining.

While the 1990 budget proposal does address some serious problems, it does so at the expense of providing for proper care of a rapidly aging veteran population which will need longer and more intensive hospital care, nursing home care, and expanded domiciliary space.

Upon review of the status of the outpatient care satellite clinics program, the 1990 budget indicates that five clinics will be activated. Nine awards are intended for fiscal year 1990. Of concern, however, is the fact that funding shortfalls may delay the activation of the five clinics. We are aware that activation funds for this fiscal year were diverted to personnel accounts.

The VA has 19 spinal cord units in operation. Four more units are scheduled. Upon review of the location and occupancy rates, we must question whether the units are being properly located to allow easy accessibility to veterans of limited mobility. The Department of Medicine and Surgery, in apparent recognition of these facts, has initiated a training program to allow them to place trained spinal cord injury personnel in outpatient care facilities to treat minor problems and refer serious conditions to one of the major centers.

The American Legion generally supports the concept of the FDP in that it identifies both short and long term needs of the VA. The program, if followed, allows for effective and timely budgeting of new construction as well as replacement and modernization of existing facilities. The program identifies needs and specific strategies necessary to accomplish these objectives.

In conclusion, Mr. Chairman, it is a goal of the American Legion to ensure that top medical care is provided to all eligible veterans. Adequate funding must be authorized and appropriated to upgrade and replace existing facilities.

Once again, we thank the subcommittee for the opportunity to present our views.

[The statement of the American Legion appears at p. 112.]

Dr. ROWLAND OF GEORGIA. Thank you, Mr. Christian.

Mr. Walsh, it seems that one of the most influential products of the veterans service organizations has been the independent budget. The American Legion didn't participate in that, I don't believe. Can you tell me why?

Mr. WALSH. That's correct, sir. We have a longstanding resolution from our membership that prohibits our working in concert with other service organizations on these sorts of matters. We do work with the other organizations on a number of issues, but we don't sign our name on to a number of these initiatives.

We really haven't had a chance to study the independent budget this year, so we are unable to really comment on it. I do have a copy here in front of me.

Dr. ROWLAND OF GEORGIA. Mr. Mansfield, maybe one of the risks of halting the facilities development plan is the VA would be left with nothing for construction planning. Do you think it's better to take such a risk and modify the FDP process as it progresses?

Mr. MANSFIELD. Sir, let me point out, as indicated in the testimony, that we believe there should be some type of planning process. We believe following up on the original '85 study is important. What we have tried to indicate here is we've had some concerns about how this one is going forward and what the costs are. An example is, as I said, you take $50 million that's indicated to be spent on this. What could we do in construction of real facilities, for example, nursing home care units. The independent budget calls for $30 million for this year and the budget has none.

So I think the point is there's a problem here. We have tried to point out the problem. We have attempted to discuss this with the folks at the VA. We would like to make sure the system works as best it can, and we would like to know that these scarce dollars are being spent the best way possible.

Let me just point out, sir, in further answer to that question, I have before me some of the data from Marion, IN. I would like to show you one of the reasons we are concerned. I know that the Congressman before read the report about the trees. I wish that Dr. Gronvall could answer questions on SCI construction in Tampa and Gainsville as quick as he could answer questions about deciduous trees.

The thing we have here, for example—and I'll pass these up—here is something about a trash house that was built in 1947 and is vacant. Here's something about a flagpole that was built in 1947. Here's a smokestack. This one, I guess, is good because it's an electrical substation. Here's a study about a monument built in 1900. The present use, a monument, historical significance, outstanding as a monument and historical marker, eligible for the historical record. Here's another one about a building constructed in 1947, the present use is vacant, being used as a childrens playhouse. Historical significance, not essential.

The point I'm making, sir, is we had some indications early on that caused us concern about this program, and that's why we have highlighted it and brought it up. As I say, we know dollars are scarce. We would like to see them used for the best benefit of the Nation's veterans. Now we come in here and hear testimony from the experts that were brought in because of pressure from the Congress to study what the VA is doing, and we find out the VA hasn't even planned to update this information. They should address how they tie it into a national construction planning system, which you would think would be the reasons they went into this to begin with. So we believe there should be some system.

Dr. ROWLAND OF GEORGIA. Thank you.

Mr. Rowland.

Mr. ROWLAND OF CONNECTICUT. Thank you, Mr. Chairman.

Gordon, in your statement you say that the VA's construction priorities are basically dollar driven, without regard to a proper long-term planning process, and that the proposed facilities planning process is flawed, that the medical district planning process fails to give accurate projections of national VA needs.

Would you go into a little bit more depth as to why you have drawn these conclusions? We would like to receive any additional information that you might have for the record on those concerns, also.

Mr. MANSFIELD. Sir, I would be happy to supply additional information for the record.

To go back to the first question, dollar driven, I think the point was brought up here earlier, what we've got here is a situation where there is no national planning that indicates the most needful projects. The way the system works is, OMB says you've got x-number of dollars, go build something. Then the VA comes up with plans to match those dollars. So it is dollar driven in that respect. It isn't "Here's what we absolutely need; here's what you need to have adequate medical care; here's what you need to take care of the veterans; here's what you need for the doctors and nurses and people that work in these facilities, to have the best space so they can do their job." You know, 811 is asked for and 400 and some is given. It's built into that. That's why we're saying it's dollar driven.

Again, I think the statement by the experts brought in here to study this FDP shows there's no national planning system. There just isn't one. We think they're moving toward that and we hope they get there soon.

I think I missed the middle question, FDP's?

Mr. Rowland of Connecticut. Yes, you mentioned that the facility planning process is flawed and that the medical district planning also fails to give any accurate projections.

Mr. Mansfield. As I said, sir, I come here as a confused advocate for Paralyzed Veterans of America. In Dallas, TX we've been through this year after year, time after time. We've got the MEDIPP system, and all of a sudden out of nowhere, after $2 million is spent on initial design, MEDIPP says "Whoops, wait a minute, 59-percent increase in ambulatory care. Let's slow down. Let's stop everything right here." My concern is we lose the ambulatory care, but we lose time on the SCI unit, too. There isn't a system out there. That's the problem.

Again, you go back to Tampa and Gainsville. PVA has come down here to fight for Gainsville based on the fact that in '85, I think, there was a decision made by somebody at the VA that there was a need for an SCI unit in Gainsville. We went through the whole process with this committee, with the Budget Committee, with the Appropriations Committee, and with the Senate. Now, all of a sudden, out of nowhere, a change in plans. I think that's another indication, that there is not an adequate, logical, consistent system that best supplies what is needed for the veteran and the best uses of scarce dollars that we're all trying to deal with.

Mr. Rowland of Connecticut. Would any of you be willing to comment on my earlier question about the possibility in the future of using facilities and—specialty is a bad word to use, but let me say converting some to long-term nursing care and perhaps specialize in some type of acute care. Do you see that as a possible solution?

You look at the renovation projects and what's happened over the years, it looks like we're going to have two a year, and if we get to all the hospitals, it will take 80 or 85 years to go. Is there a better way of doing this? If you have any remarks or thoughts off the top of your head or gut reactions, I would appreciate them. Otherwise, we can——

Mr. Mansfield. I can give you a gut reaction. I think it behooves us all that we examine new and possibly better ways of making the system work. We all realize that we have got major problems in VA health care.

I think the types of things you indicated earlier need to be looked at. I think we have to come up with some answers and work together.

Another solution may be—this comes out of a meeting with the Appropriations Subcommittee staff yesterday on Senate side—in long-term care nursing home units, something that PVA has been looking at for a while. Maybe what we need are leased facilities, because if you look at the studies, you have got a massive block of veterans that are going to be in need of nursing care units. Immediately following that veterans population is a civilian population with the same needs. If you had some type of a setup where you could have these facilities built, leased by the VA, staffed by the VA, run by the VA, for the period of need, then possibly they could be turned over to someone else to take care of the civilian needs. I think the answer is we need to look at new ways of taking care of the veterans.

Mr. **Rowland of Connecticut**. Does anybody else have any thoughts?

Mr. **Walsh**. The American Legion has been studying it in a very general sense, looking at various proposals, again looking at ways to improve health care delivery in the VA. We have not developed a final position on it as of yet. But we certainly are looking along the lines that you discussed earlier.

Mr. **Rowland of Connecticut**. Mr. Christian.

Mr. **Christian**. I've got to concur with my colleague. I might add, too, that we're conducting a survey of all 172 medical centers and the issues attached to the capabilities and limitations that serve our Nation's veterans. We don't have all the returns in yet, but upon completion of that survey, we will be happy to furnish the results to this committee, with a view perhaps toward giving you more of a basis to determine specialization.

That's a difficult question because you can't predict the workload, in terms of deciding whether you're going to select one site and specialize.

Mr. **Rowland of Connecticut**. Thank you very much.

Thank you, Mr. Chairman.

Dr. **Rowland of Georgia**. Thank you. I thank all of you for being here this morning. I appreciate it very much.

Mr. Leath has a statement that will be made a part of the record, without objection.

[The statement of Hon. Marvin Leath appears at p. 117.]

Dr. **Rowland of Georgia**. I want to express my appreciation to all of the VA representatives who stayed with us to the end of the hearing.

The hearing stands adjourned.

[Whereupon, at 11:25 a.m., the subcommittee adjourned.]

APPENDIX

STATEMENT OF HON. G.V. (SONNY) MONTGOMERY

CHAIRMAN

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

FEBRUARY 1, 1989

GOOD MORNING, THE HEARING WILL COME TO ORDER.

THE PURPOSE OF OUR MEETING THIS MORNING IS TO RECEIVE TESTIMONY ABOUT THE VA'S PROPOSED CONSTRUCTION BUDGET AND PLANS FOR FISCAL YEAR 1990. THIS IS THE FIRST HEARING OF THE 101ST CONGRESS FOR OUR SUBCOMMITTEE. SOME PEOPLE HAVE BEEN SURPRISED THAT THE FIRST TOPIC IS CONSTRUCTION.

THERE ARE SEVERAL GOOD REASONS TO HAVE THIS HEARING NOW: UNDER CURRENT LAW, APPROPRIATIONS MAY NOT BE MADE FOR CONSTRUCTION PROJECTS THAT COST MORE THAN $2 MILLION AND LEASES THAT COST MORE THAN $500,000 UNTIL SUCH PROJECTS ARE AUTHORIZED BY THE HOUSE AND SENATE VETERANS AFFAIRS COMMITTEES. SECOND, CONSTRUCTION HAS A DIRECT IMPACT ON THE AMOUNT AND QUALITY OF MEDICAL CARE THAT IS DELIVERED BY THE VA.

THEREFORE, WE INCLUDE CONSTRUCTION ITEMS IN OUR REPORT TO THE BUDGET COMMITTEE. THAT REPORT IS DUE ON FEBRUARY 25, SO WE HAVEN'T MUCH TIME.

THIRD, CONSTRUCTION ISSUES ARE ALWAYS OF GREAT INTEREST TO MEMBERS. SO, WE ARE PROVIDING A FULL HEARING EARLY IN THE SESSION. I HOPE THAT WE CAN THEN DEVOTE THE HEARINGS ON FEBRUARY 7 AND 9 TO ADDRESSING THE BUDGET FOR VA MEDICAL CARE WITHOUT AGAIN TALKING ABOUT CONSTRUCTION PROJECTS. THE MEDICAL CARE BUDGET SITUATION IS VERY DIFFICULT THIS YEAR AND WE WILL NEED A LOT OF TIME TO EXPLORE IT.

WE PLAN TO DISCUSS SPECIFIC PROJECTS TODAY -- BOTH THOSE IN THE PROPOSED BUDGET AND THOSE THAT ARE NOT INCLUDED. WE WANT TO KNOW THE BASIS FOR INCLUDING SOME PROJECTS AND EXCLUDING OTHERS. WE ARE ESPECIALLY INTERESTED IN THE ROLES OF THE FIVE YEAR CONSTRUCTION PLAN AND THE RECENT CAPITAL FACILITIES ASSESSMENT.

WE ARE INTERESTED IN LEARNING WHETHER THE RECOMMENDATIONS OF THE DEPARTMENT OF MEDICINE AND SURGERY ARE INDEED TAKEN BY THE OFFICE OF FACILITIES. LAST, WE ARE INTERESTED IN THE NEW PROGRAM CALLED THE FACILITIES DEVELOPMENT PLAN WHICH IS DESIGNED TO MAKE SENSE OF CONSTRUCTION PLANNING IN THE VA.

EVERY YEAR I SAY THANK YOU TO OUR WITNESSES. BUT I WANT YOU TO KNOW THAT WE APPRECIATE THE TIME AND EFFORT YOU PUT FORTH TO COME HERE. I DO HOPE THAT YOU WILL USE PLAIN LANGUAGE WHEN YOU TESTIFY SINCE SOME OF US MAY NOT KNOW ALL OF THE JARGON THAT IS USED FROM TIME TO TIME.

I NOW RECOGNIZE JOHN PAUL HAMMERSCHMIDT, OUR RANKING MINORITY MEMBER FOR ANY COMMENTS HE MAY HAVE BEFORE WE HEAR FROM OUR FIRST WITNESS.

CONGRESSMAN TOM CARPER OF DELAWARE AND CONGRESSMAN TOM LEWIS OF FLORIDA, AS WELL AS THE DISABLED AMERICAN VETERANS HAVE REQUESTED THAT THEY BE PERMITTED TO SUBMIT A STATEMENT FOR INCLUSION IN THE HEARING RECORD. WITHOUT OBJECTION, IT IS SO ORDERED.

OUR FIRST WITNESS WILL BE THE HONORABLE PAUL KANJORSKI OF THE 11TH DISTRICT OF PENNSYLVANIA. PAUL, PLEASE PROCEED AS YOU SEE FIT.

OUR FIRST PANEL OF WITNESSES WILL BE MS. SUSAN LIVINGSTONE, ASSOCIATE DEPUTY ADMINISTRATOR FOR LOGISTICS OF THE VETERANS ADMINISTRATION, ACCOMPANIED BY DR. JOHN GRONVALL, THE CHIEF MEDICAL DIRECTOR, MR. GERALD E. NEUMANN, DIRECTOR, OFFICE OF FACILITIES, AS WELL AS OTHERS. SUSAN, WILL YOU PLEASE INTRODUCE THE OTHERS AT THE TABLE?

OUR SECOND PANEL IS MR. DANIEL SWEDBERG OF BOOZ, ALLEN, & HAMILTON, ACCOMPANIED BY MS. ELIZABETH GRAY.

OUR THIRD PANEL CONSISTS OF MEMBERS OF AMVETS, THE JEWISH WAR VETERANS OF THE UNITED STATES OF AMERICA AND THE VETERANS OF FOREIGN WARS.

OUR FOURTH, AND LAST, PANEL CONSISTS OF MEMBERS OF THE PARALYZED VETERANS OF AMERICA AND THE AMERICAN LEGION.

THOMAS R. CARPER
DELAWARE, AT-LARGE

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AND URBAN AFFAIRS

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February 7, 1989

Honorable G.V. "Sonny" Montgomery
Chairman
Committee on Veterans Affairs
Washington, D.C. 20515

Dear Chairman Montgomery:

Last year you were very helpful to me in allowing your staff to review the need for a clinical addition to the V.A. hospital in Elsmere, Delaware. As a result of that review, you subsequently included the proposed clinical addition in last year's Major Facilities Construction Resolution. I am now seeking your support, and that of the entire Committee, in securing the funding for this important project.

It is no mystery that the Veterans Administration hospital in Elsmere needs to be expanded and brought technologically up-to-date. I have visited the Elsmere facility on numerous occasions over the past few years, and I am convinced of the need for a clinical addition to the hospital.

A clinical addition for the Elsmere hospital has been on the V.A.'s wish list for fifteen years. In 1973, the V.A. submitted a Quality of Care report to Congress. Ninety percent of the goals and objectives set forth in the report have been achieved. But one of the unmet goals set by that report has been the clinical addition for Elsmere, despite the fact that $1.5 million has already been spent on studies and plans. Few projects of such importance have been on hold for so long.

Late last year, the V.A. included the Elsmere project in their 1989 construction budget. But the Office of Management and Budget deleted the project from the Reagan Administration's overall fiscal year 1989 budget, which was submitted to Congress in February.

It is clear that the existing facility is simply not able to provide adequate services to the veterans from the Delaware, Pennsylvania, Maryland, New Jersey area. I think hospital administrator Bill Kingsley and his staff are doing their best with the inadequate resources made available to them. But an outpatient facility built in 1948 to serve twenty to thirty thousand patients cannot be expected to serve between sixty and seventy thousand patients in 1988. From both a space and a technological perspective, the facility is inefficient and obsolete.

That is why funding for this project now is so important. In addition to the new outpatient area, the structure would also include a new lab service area, a radiology center, and a new pharmacy.

In these days of limited resources, Congress faces difficult decisions as we establish spending priorities. No new spending should escape close scrutiny. The Elsmere addition can't be built overnight. But I think a majority in Congress will agree that the Elsmere addition is money well spent.

Thank you for any assistance you might provide.

Sincerely

Tom

Tom Carper
Member of Congress

TC/jb

Any additional help you could extend to us on this project would be greatly appreciated, Sonny!

TOM LEWIS
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SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

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Statement of The Honorable Tom Lewis Before the Subcommittee on Hospitals and Health Care

February 1, 1989

Thank you, Mr. Chairman, for the opportunity to testify in strong support of the Department of Veteran's Affairs' Palm Beach Medical Center, which is projected to be completed in 1992. As you listen to tesimony from myself and others, along with studying the facts, I believe it will become apparent to the Committee how dire the need is for the proposed 240 bed nursing home which was previously contained in this facility.

As you know, construction of a Veterans Medical Center in West Palm Beach, Florida has been authorized for a number of years. In 1986 a site was chosen, and preliminary contracts were awarded. Last month, the Veterans Administration announced a contract worth over $5 million for architectural and engineering costs for the medical center, laundry, and an 887 car parking garage.

The original design of the medical center called for a 625 bed hospital along with a 240 bed nursing home. Since the area's Veteran population is rapidly aging, and the need for hospital beds is declining, the Veterans Administration made a decision, which I supported, to cut the hospital from 625 to 400 beds while maintaining their commitment to the nursing home.

The rapid aging of South Florida's veterans has served to reinforce my belief in the importance of a nursing home to serve the many elderly veterans in this area. Southern Florida has over 200,000 veterans at the present time, with more moving in every day. At the present time, the only nursing home to service veterans is the 212 bed facility in Miami. This nursing home is simply too small and too far away. The 200,000 South Florida veterans deserve the peace of mind that another nursing home would bring.

For these reasons, I was dismayed to find that the proposed nursing home was dismissed from the recent budget submitted by President Reagan's Administration. Last year, you may recall that the Administration did not request this proposed nursing home. Your committee, realizing its importance, placed it back in the budget. I ask that you do so again.

We cannot ignore the long-term health care needs of these men and women who gave of themselves to protect our nation in its time of need. There is an undeniable need for the nursing home as an important part of this medical center. To eliminate it closes the door to the greatest test this country faces in its commitment to our aging veterans.

Mr. Chairman, I urge this Committee to return the nursing home to the Palm Beach Medical Center, and I would like to again thank this Committee for the opportunity to testify on behalf of the Palm Beach Medical Center in its entirety.

In closing, allow me to compliment this Committee for their unwavering support of this nation's veterans. As a veteran myself, I have long been interested in veteran's concerns, and have always enjoyed working with this Committee to ensure that veterans are treated fairly.

STATEMENT OF
DAVID W. GORMAN
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
FOR MEDICAL AFFAIRS
DISABLED AMERICAN VETERANS
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
HOUSE COMMITTEE ON VETERANS AFFAIRS
February 1, 1989

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the over 1.1 million members of the Disabled American Veterans and its Ladies' Auxiliary, I would like to take this opportunity to thank you and the members of the Subcommittee for allowing us the opportunity to present our views on the Department of Veterans Affairs Construction Program Budget request for Fiscal Year 1990.

Mr. Chairman, the Fiscal Year 1990 budget requests a construction program level of $487,623,000 to support projects for the Veterans Health Services and Research Administration, the Veterans Benefits Administration and the National Cemetery System.

The appropriation request is comprised of $365,849,000 for major projects, $114,699,000 for minor projects and $7,075,000 for the Parking Garage Revolving Fund.

Of the total program level request, $417,502,000 is for medical facilities projects including the Parking Garage Revolving Fund; $3,300,000 for the regional office projects; $15,480,000 for the National Cemetery Program; $10 million for staff offices; $500,000 for the emergency fund; and $45,100,036 for general administration.

Highlights of the medical facilities major construction program include:

* $183,004,000 for replacement and modernization projects;

* $76.3 million for general and miscellaneous projects;

* $16.5 million for clinical improvements;

* $27.2 million for fire and safety improvements;

* $2 million for nursing home improvements;

* $13.6 million for the design fund;

* $24.8 million for the advance planning fund;

* $32 million for asbestos abatement;

* $3 million for electrical improvements;

* $2.5 million for elevators;

* $12 million for hazardous waste abatement;

* $3 million for heating, ventilation and air-conditioning projects;

* $9 million for seismic improvements; and

* $5.6 million for research and education facilities

Mr. Chairman, a review of the VA's Fiscal Year 1990 construction request for medical programs reveals that the VA's ability to provide quality medical care in an appropriate setting is being placed in jeopardy.

Simply stated, while we support full funding of the proposed construction program, we are nevertheless concerned, not only with the quality of care currently being provided, but also about the VA's ability to meet the pressing demands being placed upon its health care system.

The DAV is concerned, as I know you are, Mr. Chairman, with how the VA will provide quality health care to the rapidly increasing aging veteran population.

We know that greater numbers of elderly veterans are seeking nursing home care from the VA, yet, of this medical construction budget, less than .5% ($2 million) is requested for nursing home care bed conversion, renovation, and relocation.

Furthermore, while more and more elderly veterans are seeking nursing home care from the VA, this construction request reflects the continued policy of shifting the responsibility for VA nursing home care to non-VA facilities. As a result, desperately needed new VA nursing home care projects and new bed construction are not forthcoming.

In an era of clear and increasing need for new VA nursing home care units, we are at a complete loss to understand the rationale used to cancel a major 117 nursing home care bed conversion project at the West Los Angeles, California, VA Medical Center and simply transfer the designated funding to the working reserve account.

While we support the proposal to convert 363 hospital beds to nursing home care beds, we are skeptical of such a conversion actually occurring. It is readily apparent -- from emperical observations -- that a great deal of reluctance exists toward converting any meaningful number of acute care beds to long-term care beds.

As you know, Mr. Chairman, the Medical District Initiated Program Planning (MEDIPP) is used as a plan to assess the system's future needs based upon a medical district's prospective and the shift in veteran population.

Additionally, MEDIPP is capable of assisting in the construction program by integrating grass roots, programmatic planning; developing early conceptualization of facility construction needs; and by expanding the flexibility of space criteria to meet changes in mission requirements.

Mr. Chairman, the DAV supports the facility planning concept embodied in MEDIPP -- making the most cost-effective use of resources and funding that is available. The program should not only continue to provide input in the construction planning process but the involvement of individual medical center directors should be intensified during virtually all phases of the process.

The VA's Fiscal Year 1990 construction request includes 24.8 million for the Advance Planning Fund (APF). As we understand it, the APF is designed to provide flexibility to explore various corrective strategies, propose alternative conceptual approaches and enable informed decisions to be made.

Additionally, the VA is requesting 13.6 million in Fiscal Year 1990 for the design fund. This fund, with certain restrictions, permits the VA to initiate working drawings for construction projects prior to final Congressional approval for funding. By using this process, the VA has estimated a significant time delay may be eliminated, thereby producing savings to the VA by the avoidance of additional inflationary cost.

Grants for Construction of State Extended Care Facilities

As you are aware, Mr. Chairman, this program provides grants to assist states to acquire or construct state home facilities for furnishing domiciliary or nursing home care to veterans and to expand, remodel, or alter existing buildings for furnishing domiciliary, nursing home or hospital care to veterans in state homes.

The VA's Fiscal Year 1990 appropriation request of $42 million will produce 760 nursing home and 326 domiciliary beds.

Recognizing the significant and important role of state veterans homes -- in terms of care provided to the rapidly aging veteran population and the cost-effective use of federal taxpayer dollars that supplement this program -- we believe it is indeed wise to continue funding this program that ultimately produces savings to the government in terms of both construction and health care costs.

Mr. Chairman, we find it very distressing to note the meager funding request ($16.5 million) for clinical improvements. Recognizing that the medical community at large -- of which the VA is an integral part -- is directing resources and treatment modalities away from the institutional settings and more toward ambulatory care settings, we are extremely concerned with the VA's ability to furnish quality health care services without consistent and progressive expansion in the ambulatory care arena.

In Fiscal Year 1990 the VA projects treating 825,000 more outpatients than will be treated in Fiscal Year 1989. Also, nearly 18,000 fewer veterans will be treated as inpatients, a significant number of which, we believe, will be alternatively referred to outpatient clinics for treatment.

In view of the large volume of patients now being furnished ambulatory care, the projected large influx of new patient visits and the current space and functional deficiencies, there exists a need to direct sufficient funds to help alleviate the current adverse situation existing within the system of outpatient clinics.

Facility Development Plan

Mr. Chairman, it is our understanding that the Fiscal Year 1990 budget request includes $10 million for the completion of Facility Development Plans (FDP).

FDP's are a nationwide initiative that include all VA medical centers. These plans will provide a comprehensive, nationwide assessment of the condition of VA medical centers needs to the year 2000 and beyond. An FDP will be completed for each VA Medical Center thus providing an assessment of all the medical, functional, and physical plant needs of individual medical centers as projected by the VA's medical planning system. FDP's will also provide for the expansion, renovation, and replacement needs to fulfill the mission of each medical center.

Mr. Chairman, there should be no hesitance in stating the concept of FDP's are sound and the various data and information that will be forthcoming upon their completion is desperately required in concert with the operation of the VA health care delivery system.

There has, however, been some controversy surrounding the procedures used in the development and execution of the FDP's...specifically factors such as costs, timeliness, usefulness of collected data, the overall effectiveness of the process and the existing degree of formating consistency to evaluate and analyze the available data.

Mr. Chairman, we have received some assurances from the Office of Facilities that the entire FDP process is, in its present format, a viable and workable concept that will produce the required and anticipated results in a reasonably timely and cost-efficient manner.

Being mindful of the controversy surrounding this issue, we will be keeping a watchful eye on the progress of the FDP's to insure the stated purpose is met and the construction program is not placed in further jeopardy.

Finally, Mr. Chairman, we would urge the Subcommittee's careful consideration of the recommendations and funding levels as contained in the Independent Budget for Veterans which has been provided to the Subcommittee. This budget document represents the cumulative and cooperative efforts of several major veterans service organizations (DAV, AMVETS, VFW and PVA) and represents, in our view, a realistic funding level that would allow the Agency to carry out a meaningful program of meeting the VA's overall construction needs.

Mr. Chairman, this concludes my testimony and, once again, I want to thank you for allowing us the opportunity to present our views on this most important issue.

TESTIMONY OF

Congressman Paul E. Kanjorski

TO THE

House Veterans' Affairs Subcommittee on
Hospitals and Health Care

On the Need to Authorize
the Wilkes-Barre VA Medical Center
Modernization and Renovation Projects

February 1, 1989

The VA Medical Center in Wilkes-Barre, Pennsylvania has very serious fire and health safety deficiencies that must be corrected. However, due to funding constraints, the Veterans' Administration has delayed action on these projects for over a decade and does not intend to make a funding request until 1992. These delays only serve to deny veterans quality care, threaten their safety, and increase the cost of these projects to the taxpayers. Only an authorization from this committee can end the delays of these projects.

According to officials at the Veterans' Administration, the VA Hospital in Wilkes-Barre serves 270,000 veterans of our area. The outpatient workload of the facility amounts to 111,000 annual visits and is projected to exceed 126,000 visits in 1994. The 1950 design of this facility is inadequate to serve the health care needs of the area.

According to hospital officials, the facility violates federal, state and local fire codes. Existing sprinkler systems only provide protection for closed areas considered at high risk, such as storage closets. They do not provide protection for the entire complex. Additionally, the number of smoke detectors is insufficient to meet the hospital's needs and many beds are too far from fire exits to allow patients sufficient time to evacuate in the event of an emergency.

Significant health hazards exist. The air conditioning unit was built in the 1960's, and does not provide the number of air exchanges comparable to that of modern systems. This causes air to stagnate, which not only affects the comfort of the patients, but also provides more opportunity for bacteria to grow, diminishing patient safety.

The quality of care that can be provided is also insufficient. There are space shortages in nearly every service ranging from radiology and cardiac care to respiratory and dialysis care. There are as many as 16 patients in one room. These patient care and privacy deficiencies must be addressed. In addition, outpatients must wander throughout the hospital, including patient wards, in order to search for outpatient facilities. The general admitting entrance also acts as the emergency entrance. It is necessary to consolidate these outpatient facilities which are dispersed throughout the entire complex.

The modernization and renovation projects go hand in hand. The modernization project, estimated to cost $47.5 million, involves the construction of a new wing and will address deficiencies in admitting, outpatient and related clinical services. It will free the necessary space to begin renovation. The renovation project, estimated to cost $16.1 million, will then address fire and safety, patient privacy deficiencies and will modernize air conditioning in the existing facility.

Due largely to funding shortages, the Veterans' Administration has dragged its feet on these projects. Correction of the fire and safety deficiencies was first proposed by the Wilkes-Barre VA Hospital in 1977. Correction of outpatient facility and inpatient ward deficiencies was proposed by 1979. However, it was not until 1984 that the Veterans' Administration approved the "advanced planning" of these projects. Therefore it took 7 years for the VA to approve and begin the planning of the initial project.

The Veterans' Administration has been "advance planning" for four years. Yet, the VA does not intend to hire contractors to design the preliminary drawings until June of 1989. Perhaps most indicative of the VA's delay tactics is that it intends to begin "considering" funding for the working drawing design/construction in 1992. That means that despite the fact that it only takes 10 to 12 months to complete the preliminary design, which should clear the way for the working design by early 1990 according to its own schedule, the VA intends to delay it until 1992. This is a further delay of 2 additional years.

It is important to emphasize that the VA has determined that modernization, which will physically expand the VA facility and consolidate outpatient facilities, must be done before fire and safety problems can be addressed. Therefore, if all goes well according to the VA's elongated schedule, the corrections to serious fire and safety deficiencies will not even be begun until 1993. This timetable is unacceptable. The facility is an accident waiting to happen.

I understand that this Committee must be mindful of existing budget constraints. Otherwise, it may lose its credibility. However, the Veterans' Affairs Committee must maintain its authority to set priorities and authorize projects according to real needs. Given the serious space, health, and fire safety deficiencies that must be corrected at the VA Medical Center in Wilkes-Barre, and given the long delay in beginning these projects, I think it is clear that the completion of these projects is a top priority. Further, the total expense of these projects, $63.6 million, although significant, will not break the budget.

Last Congress, this Subcommittee held a hearing concerning 13,000 VA beds taken out of service. At that hearing, it became clear that the VA experienced severe budget shortfalls and that the Administrator had not requested funding reflective of real needs. If this committee fails to request funding for the modernization and renovation of the Wilkes-Barre facility, it can be accused of the very same misjudgment.

Mr. Chairman, colleagues, I respectfully request that you support adding these projects to those to be authorized by the FY 1990 Construction Resolution.

STATEMENT
BY
SUSAN LIVINGSTONE
ASSOCIATE DEPUTY ADMINISTRATOR FOR LOGISTICS
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES
ON
FEBRUARY 1, 1989

Mr. Chairman and members of the Subcommittee, I am pleased to appear before you this morning to present testimony concerning the Department of Veterans Affairs' construction request contained in the President's budget for fiscal year 1990.

Introduction

The Department of Veterans Affairs (VA) has the largest medical facility construction program in the nation. This includes a tremendous capital investment represented by our 5,000-plus buildings and some 27,000 acres of land. The VA owns approximately 123 million square feet of space and occupies nearly 7 million square feet of GSA-controlled space.

It is critical to our mission that we preserve, maintain and enhance this physical plant to insure its capability to deliver state-of-the-art medical care and to respond to the changing needs of our nation's veterans. This FY 1990 budget request continues our commitment to a capital investment program which responds to these goals.

FY 1990 Request

The FY 1990 budget requests a construction program level of $487,623,000 in support of projects for the Veterans Health Services and Research Administration (VHSRA), the Veterans Benefits Administration (VBA) and the National Cemetery System (NCS). This amount includes an appropriation request for major projects of $365,849,000, a minor program request of $114,699,000 and a parking garage revolving fund request of $7,075,000.

Of the total $487,623,000 requested, $413,207,000 is for medical care facilities projects including the Parking Garage Revolving Fund; $3,300,000 is for VBA regional office projects; $15,480,000 is for the national cemetery program; $10,000,000 is for staff offices; $500,000 is for the Emergency Fund; and $45,136,000 is for general administration.

Sites

This FY 1990 construction budget includes funding for construction of a major Replacement/Modernization project in Newington, Connecticut, and a New Medical Center in Palm Beach, Florida.

Funds are included for the Environmental Improvements, Patient and Nursing Home Care Buildings project in North Chicago, Illinois, to restore funds which were transferred from Phase II of this project to the Major Working Reserve and reprogrammed to allow the construction contract award for the Outpatient Clinic Addition project in New York, New York.

The request includes design funds for Structural Seismic Corrections in Long Beach, California; and construction funds for a VA/Air Force joint venture medical center at the Nellis Air Force Base in Las Vegas, Nevada.

An Outpatient Clinic Addition in Dublin, Georgia; a New Psychiatric Building in Columbia, South Carolina; Renovation of Medical Buildings in Lyons, New Jersey, Salt Lake City, Utah, and Waco, Texas; and Cemetery Gravesite Development at the national cemeteries in Fort Snelling, Minnesota, and Jefferson Barracks, Missouri, are also all included in this request.

Planning and Development

The FY 1990 major facility construction budget request is a product of the planning and development efforts of the many offices within the VA in the context of available budget resources. The major projects included in this request have been developed utilizing an advance planning process . . . funded through the Advance Planning Fund (APF) . . . which provides detailed definition of need in terms of space, function and technical requirements.

For the VHSRA, the Medical District Initiated Program Planning (MEDIPP) process serves as the initial programmatic basis of our construction planning.

This process, which identifies medical programs and levels of service, is reviewed, modified, if necessary, and approved in Central Office. MEDIPP serves as the basis for the development of each medical center's five-year facility plan. This plan identifies facility requirements and projects to correct deficiencies and to provide the necessary physical plant to meet our programmatic objectives.

Based on Congressional funding support, we are currently initiating improvements in our planning and prioritization system, which will result in more uniform, consistent planning data and improved documentation of decision-making. This will be accomplished through our facility development plans (FDPs).

Our FY 1990 budget includes within the Advance Planning Fund $10 million for continuing the nationwide initiative to provide facility development plans for all of our medical centers. FDPs will provide a comprehensive, nationwide assessment of medical center facility needs into the next century. An FDP will be completed for each VA medical center. It will provide an assessment of all the functional and physical plant needs of the individual medical center. Each FDP will also provide a reasoned plan for the expansion, renovation and replacement needed to fulfill the mission of each of our medical centers.

The joint venture of Booz, Allen Hamilton/RTKL Associates (BAH/RTKL) recently completed an evaluation of our four pilot FDPs and has concluded that the pilot FDP implementation has been a success and has recommended the continued implementation of the FDP program. BAH/RTKL has recommended minor refinements to the process, and most of these have already been adopted.

Tremendous benefits will be forthcoming from the FDP program. Examples of these benefits include providing veterans with appropriate modern facilities in the right place at the right price; improved five-year VA medical facility plans; providing a basis for an overall facility management approach; improved Agency oversight toward achieving national goals and objectives; consistent planning data in a computerized data base for future decisionmaking; establishment of a "corporate memory" of planning decisions; improved planning/coordination between departments; construction consistent with program priorities; and improved facility and project planning.

Once completed, these facility development plans, which will be annually revalidated and updated, will help us to greatly refine our facility planning, assist us in prioritizing construction projects and help us in scheduling and allocating construction budget resources. Indeed, these FDPs will provide the VA and the nation's veterans for the first time with integrated, systemwide, documented plans to meet the facility requirements of VA medical centers and the needs of veterans in the years to come.

Planning for nursing home beds continues to center on converting existing underutilized hospital beds to nursing home care (NHC) beds in lieu of new construction. Prior to approval of any request for additional VA-owned or operated nursing home care beds, a thorough assessment, which explores the potential for meeting the need through state home beds, community beds or conversions, will be completed. Two million dollars is included in our minor program request to support additional NHC beds by means of:

1. conversion of existing hospital beds;
2. renovation of existing NHC wards to meet VA criteria; and
3. relocation of existing NHC beds to renovated space which is more suitable to our NHC program needs.

With regard to spinal cord injury (SCI) units, a number of factors are taken into consideration in determining their location. These include a demographic analysis of the projected need for these specialized services and the location of the existing SCI units. The potential for the integration of a new unit into other clinical and research activities is also considered.

The VA has been a leader in both the operation and construction of these highly specialized units. Currently, the VA has over 1,300 operating SCI beds at 19 different medical centers in 14 different states and Puerto Rico.

In the past five years (1983-1988), the VA has completed construction of eight SCI centers in Hampton and Richmond, Virginia; Seattle, Washington; Brockton, Massachusetts; Memphis, Tennessee; Miami, Florida; and San Diego and Long Beach, California.

In addition to these eight newly completed SCI projects, we have also received funding for six additional spinal cord injury projects at Albuquerque, New Mexico; Hines, Illinois; Houston, Texas; Palo Alto, California; Dallas, Texas (design only); and San Antonio, Texas. In terms of the future, a number of additional SCI projects also are in the planning pipeline. These SCI projects are to be located in Salt Lake City, Utah; Augusta, Georgia; Tampa, Florida; and Long Beach, California.

In addition to these special SCI projects, the VA also has modified a number of our nursing home designs to provide enlarged bedrooms and special bathroom facilities which would accommodate spinal cord injured veterans. To date, Congress has already funded 19 nursing homes which will provide these specially designed facilities providing nearly 100 beds which can accommodate veterans with paralysis resulting from spinal cord injury.

Planning for colocation of Veterans Benefits Administration regional offices onto existing VA-controlled grounds continues to be pursued as an alternative means of housing VBA employees and functions. Under certain conditions, colocation can be a positive means of delivering benefits and services to veterans and their dependents.

While the Department is committed to an aggressive schedule for the development of colocation projects where cost effective, their inclusion in the major construction budget submission, for a particular fiscal year, is affected by budgetary constraints and the priorities of the Department's overall construction program.

Although no major construction funds are included in the FY 1990 request for colocation projects, $700,000 is requested for advanced planning and $600,000 is requested for design of VBA colocation projects. Two million dollars is also requested in the minor construction account for renovations and modifications to existing VBA regional office space.

The Last Five Years

The VA is proud of its construction program and believes our FY 1990 request is reasonable in the current environment of constrained budget resources. For the five-year period (FY 1985-FY 1989), the VA's construction program received $3.3 billion in funding to build new medical, cemetery and regional office facilities. This five-year program level reflects an 18 percent increase in VA construction dollars in actual terms over the previous five-year period (FY 1980-FY 1984) and has enabled the VA to accomplish many critical projects. Even in terms of real dollars, this represents a stable funding level over the last five years.

During the past five years alone, we have completed numerous major construction projects, including 12 major hospital projects replacing older facilities with state-of-the-art, medical facilities housing over 5,500 beds; 22 nursing homes providing 2,280 beds; and 3 new national cemeteries at Ft. Mitchell, Alabama; Pruntytown, West Virginia; and Bushnell, Florida. With specific reference to nursing home beds, it should be noted that between FY 1981-FY 1989, the VA received major construction funding for 44 nursing home care unit projects, with more than 5,000 beds either already built or soon to be in construction.

FY 1988 Accomplishments

We are pleased to report that in FY 1988, the VA obligated over $701 million in construction appropriations. Major awards included $68.8 million for construction of a Bed Replacement/Modernization in Dayton, Ohio; $62.8 million for Phase I of an Environmental Improvements, Patient and Nursing Home Care Buildings in North Chicago, Illinois; and $49.4 million for an Outpatient Clinical Addition and Nursing Unit in Salem, Virginia. In the minor category, the VA obligated $4.4 million more in FY 1988 than the $170.6 million we obligated in FY 1987, which was a record year. Currently, over 3,500 (major, minor and minor miscellaneous) projects, totaling more than $9.4 billion, are in the planning, design or construction stages.

A variety of major construction projects also were completed in FY 1988. Nursing Home Care projects were completed at Lyons, New Jersey, and San Antonio, Texas; and Clinical projects were completed in Fayetteville, North Carolina, Charleston, South Carolina, and Temple, Texas. In addition, Ambulatory Care projects were completed at Shreveport, Louisiana, and Altoona, Pennsylvania; Spinal Cord Injury Units were completed at Long Beach, California, and San Diego, California; and a Replacement/Modernization project was completed at New Orleans, Louisiana.

We also are most pleased to note that major strides were made in FY 1988 in the area of lease awards for space to house VA outpatient clinics. Awards were made in connection with 13 significant leasing actions. Four awards were made for leasing of space to accommodate new outpatient clinics in Ocean County, New Jersey; Ponce, Puerto Rico; Savannah, Georgia; and Superior, Wisconsin. In addition, nine awards were made for relocation, expansion, renewal or extension of existing outpatient clinics in leased space at Birmingham, Alabama; Greenville, South Carolina; Knoxville, Tennessee; Los Angeles, California; Riviera Beach, Florida; San Antonio, Texas; Buffalo, New York; Lowell, Massachusetts; and St. Petersburg, Florida. In addition, a new VA outpatient clinic presence was activated in Lawton, Oklahoma, in August 1988 under a sharing agreement with Commanche County Memorial Hospital.

Under our real property program and in compliance with the requirements of Executive Order 12512, 31 land utilization surveys were also initiated at VA medical centers. As a result of the VA's survey program and decisions made within the VA, 2.39+ acres of land and buildings at the medical center in Lincoln, Nebraska, and 16+ acres of land and buildings at the medical center in Little Rock, Arkansas (Roosevelt Road), were declared excess to the needs of the VA and formally accepted by the General Services Administration (GSA). Under the provisions of Public Law 100-322, funds realized by GSA from the sale of this property will be deposited into the VA's Nursing Home Revolving Fund.

In FY 1988, the VA achieved over $10 million in cost savings on construction projects through value engineering (VE). In fulfilling our commitment to quality health care facilities, we are acutely aware of the need to deliver the highest quality facilities in a timely fashion at the best possible price.

Recent Initiatives

The VA continually seeks to improve the time, cost and quality factors in our capital facilities program. During the past few years, we have undertaken a number of initiatives. Following are some highlights:

- FACILITY DEVELOPMENT PLANS (FDPs) - In FY 1988, significant progress was made in the implementation of one of the most important recommendations identified by the Department to improve the VA's health care facility construction process. The preparation of FDPs for all VA medical centers will substantially enhance our facility planning process.

  As noted previously, the FDP is a written, comprehensive, integrated plan which depicts the conceptual approach to the development of a VA medical center over a specific long-range planning horizon. The FDP is based on current and projected health care and facility development requirements and results in a selected facility development strategy and logical grouping of construction activities to implement that strategy and meet the needs identified for each VA medical center in serving our nation's veterans.

During FY 1988, the VA tested a process for developing FDPs at four pilot locations (Northport, New York; Marion, Indiana; Marion, Illinois; and Long Beach, California) and contracted with an independent consultant to evaluate the pilot facility development planning process to ensure that it meets necessary requirements and provides feedback and guidance for use in developing future FDPs. Based on the results of this evaluation, the VA has proceeded with full implementation and in FY 1988, awarded contracts to prepare FDPs at 80 VA medical centers.

- INTERACTIVE MEDICAL FACILITIES PLANNING (IMFP) - The interactive medical facilities planning (IMFP) system instituted in 1988, is an automated space planning system that identifies space planning criteria for VA facilities. Based on the necessary staffing and workload inputs, IMFP provides the project planner a room-by-room listing of the space requirements for a given facility and gives the planner the ability to interactively update and edit these requirements.

  The system also will be used for facility comparative analysis and the testing of planning alternatives. The IMFP has been used for space planning modeling for the first 80 facility development plans.

- CAPITAL FACILITIES STUDIES - First initiated in 1984, capital facilities studies (CFS) are comprehensive, systemwide technical evaluations of the physical plant of 132 VA medical facilities built prior to 1970 based on the existing functional usage. The data generated is utilized by the VA to address both current and future construction needs. The CFS are used currently to evaluate the viability and priority of proposed projects and will be one of the foundations for the facility development plans.

  All of the studies have been completed, and the updating phase of the CFS is already underway. The Executive Digest was recently transmitted to Congress. The studies indicated that the VA's physical plant, particularly given the age of many buildings, is in very good condition. Funding has been requested in FY 1990 to perform capital facilities studies for a portion of those medical facilities built after 1970, as well as selected national cemeteries.

- ASBESTOS ABATEMENT PROGRAM - The VA's asbestos abatement program is extensive, and its execution requires a substantial expenditure of funds and resources. Most VA facilities were built before the mid-1950s and, consequently, contain significant amounts of asbestos. All asbestos presenting an imminent hazard to patients, visitors, employees, etc., has been removed, and the removal of other asbestos is being dealt with as part of renovation or remodeling projects as applicable.

  VA asbestos abatement projects adhere to all applicable local and Federal regulations and standards, including occupational, safety and health administration (OSHA) regulations. The VA recently issued a policy document which clarifies and coordinates asbestos policy throughout the VA. It establishes strict criteria for the protection of all patients, visitors and workers, as well as stringent procedures to be followed for the abatement of asbestos in all VA facilities.

- ENERGY CONSERVATION PROGRAM - In an effort to control medical facility energy operating costs, the VA continues to effectively manage an energy conservation program. Since 1975, over $322 million in reduced utility costs have been achieved. The VA is widely accepted as one of the leaders in the energy management field and in 1988, was selected to receive three awards from the Federal Interagency Energy Policy Committee and the Department of Energy.

  The VA received 2 of the 15 awards designated for organizations (VAMC Big Spring, Texas, and VAMC Martinsburg, West Virginia), and 1 of the 15 awards designated for individuals (Albert Iamiceli, VAMC Batavia, New York).

The major benefactors of the energy management program are the recipients of VA medical care, the nation's veterans. The savings from this program have allowed resources otherwise unavailable to be used to improve medical care programs. We have been and are continuing to fund such highly technical, state-of-the-art energy conservation projects as cogeneration and direct digital control systems to improve on our program goals.

- PRIORITIZATION METHODOLOGY - The VA's construction budget development process was significantly improved in 1986 by development of a new methodology to assist in prioritizing major medical construction projects. This prioritization methodology, which undergoes continued refinement, has been used in all subsequent annual construction planning, construction budget submissions and development of the five-year medical facility development plan. The prioritization methodology has been a beneficial tool to ensure stability and objectivity for construction planning and to prepare projects for budget requests.

- DESIGN PROCESS - Other advances include restructuring design activities to resolve functional and scope issues earlier in the design process and improving the VA's design and construction standards. A spinal cord injury (SCI) design guide has been completed to better communicate the functional and technical requirements for our future SCI facilities. This pilot design guide will serve as a pattern for the continuing development of other type design guides which will eventually cover all spaces in our facilities.

Summary

As set forth in this testimony, we are constantly striving to improve and refine our planning, design and construction processes. Our mission in the VA's construction program is to provide timely, efficient and cost-effective management and support the Department's integrated capital facilities programs. We take that mission very seriously.

Mr. Chairman, we would like to thank you for the opportunity to appear here today, and my colleagues and I would be pleased to answer questions that you or the other members may have.

FY 1990 MAJOR CONSTRUCTION PROJECTS

The following major projects were forwarded to the Office of Management and Budget (OMB) for inclusion in the FY 1990 Budget. Footnotes indicate the reason, if known, for project deletion by OMB from inclusion in the President's Budget to Congress.

Location	Description	Score	(000's) Cost	Category	In Final 1990 Budget	Appealed to OMB
Lake City, FL 1/	120 Bed Nursing Home Care Unit	18.24	$ 8,000	NHC	No	No
Salisbury, NC 1/	Renovate Building 21 for Nursing Home Care & Administrative Uses	18.04	9,000	NHC	No	No
Waco, TX	Renovate Buildings 4, 7 & 11	15.42	19,200	F/S	Yes	No
Newington, CT	Medical Center Modernization (C)	15.36	53,745	Repl/Mod	Yes	No
Palm Beach, FL	New Medical Center (C)	15.36	112,025	Repl/Mod	Yes	No
Columbia, SC	New Psychiatric Building	14.88	10,600	General	Yes	No
Lyons, NJ	Renovate Building 53	14.36	10,700	General	Yes	No
Nashville, TN	Clinical Improvements and Patient Privacy	14.24	39,100	Clinical	No	Yes
Knoxville, IA 2/	Laundry Replacement	14.18	5,500	General	No	No
Salt Lake City, UT	Renovate Building 1	14.17	26,600	General	Yes	No
East Orange, NJ	Relocate/Consolidate Research	13.76	3,100	Research	Yes	No
Dublin, GA	Outpatient Clinic	13.47	9,500	Clinical	Yes	No
North Chicago, IL 3/	Environmental Improvements Patient & Nursing Home Care Buildings	13.28	17,234	Repl/Mod	Yes	Yes
Temple, TX	Bed Addition	13.1	46,300	General	No	No
Salt Lake City, UT	Spinal Cord Injury/Rehabilitation Center and Canteen	12.71	16,000	Clinical	No	No
Wilmington, DE	Clinical Addition	12.28	28,800	Clinical	No	No
Reno, NV	Clinical and Bed Addition (D)	12.17	8,850	Repl/Mod	No	Yes
Detroit, MI 4/	Replacement & Modernization (C)	11.62	10,000	Repl/Mod	No	No
Bonham, TX	Domiciliary Replacement	11.49	12,400	Dom	No	No
Long Beach, CA	Structural Seismic Corrections (D)	10.4	6,000	Seismic	Yes	No
Gainesville, FL	290 Bed Psychiatric Building (D)	10.07	8,900	Repl/Mod	No	No

The following projects do not have prioritization scores from the methodology. The methodology is not presently applicable to DVB and DMA projects. It has not been applied to the one medical project, since the current prioritization methodology does not adequately address joint venture projects with the Department of Defense.

Location	Description	($ 000) Cost	Category	In Final 1990 Budget	Appealed to OMB
Cleveland, OH	Regional Office	$18,600	DVB	No	No
Fort Snelling, MN	Gravesite Development	3,050	DMA	Yes	No
Jefferson Barracks, MO	Gravesite Development	4,430	DMA	Yes	No
Las Vegas, NV	VA/Air Force Joint Venture Medical Center Nellis Air Force Base	9,300	Clinical	Yes	No
Montgomery, AL	Relocate Regional Office to Agency-owned Grounds	7,200	DVB	No	Yes
Nevington, CT	Relocate Regional Office to Agency-owned Grounds	7,300	DVB	No	No
Parking Revolving Fund					
Detroit, MI	Parking Garage	13,000		No	No
Palm Beach, FL	Parking Garage	7,075		Yes	No

In summary, the VA appealed that the following projects be included in the FY 1990 construction request:

Montgomery, AL - Relocate Regional Office to Agency-owned Grounds
Nashville, TN - Clinical Improvements and Patient Privacy
North Chicago, IL - Environmental Improvements Patient and Nursing Home Care Buildings
Reno, NV - Clinical and Bed Addition

OMB agreed to allow the VA to include the North Chicago, IL, project, which was not in the original submission to OMB. OMB denied the inclusion of the other projects.

WHITE PAPER

SUBJ: SHARED ENERGY SAVINGS PILOT TEST PROJECT/ENERGY MANAGEMENT PROGRAM

A. SHARED ENERGY SAVINGS PILOT TEST PROJECT:

o The VA in accordance with P.L. 99-160 was directed by the Senate Appropriations Committee to initiate at least one energy services pilot test project at a typical hospital.

1. VAMC, Perry Point, Maryland was selected as the site for this pilot test project in 1987. The selection was based upon the following:

a. Large campus style facility over 1.5 million gross square foot area.

b. General Medicine and Surgery and Psychiatric hospital.

c. A laundry plant, central chiller plant, and boiler plant was present.

d. Many types of Heating, Ventilating, and Air Conditioning (HVAC) Systems existed which would offer a contractor different capabilities for possible retrofit.

e. An Energy Management System to control existing HVAC Systems was present.

f. Annual utilities consumption was over $1.75 million.

2. All required activities were undertaken to accomplish this project and monthly progress reports were sent to various congressional committees.

3. Since no proposals were received from prospective contractors in response to the VA solicitation for offers on this project, the VA requested that Congress exclude the VA from further participation in this program. An investigation to determine why no proposals were submitted was conducted and the following comments were received from prospective offerors:

a. "The VA has an excellent energy conservation program. Co-generation would be the only way to go, but they have problems with Philadelphia Electric Company that serves the Perry Point area."

b. "Perry Point already has a Honeywell Delta Energy Management System with plans to extend it. Also, buildings are too small and spread out."

c. "Perry Point's management has already undertaken the most important energy savings measures, there is little chance of providing savings of that magnitude without selling excess electricity to a private electric company which is prohibited by P.L. 99-272, section 804(2)(B)."

4. On April 12, 1988, The Director, Budget Service (041) received a call from Mr. Thomas Van Der Voort and Mr. Paul Thomson of the Senate and House Appropriations Committee informing him that the appropriations subcommittee chairmen (Senator Proxmire and Congressman Boland) did not oppose their proposal to cancel the Energy Services Pilot Test project of the VA. On May 22, 1987, the VA received a letter from Honorable G. V. (Sonny) Montgomery, Chairman, Committee on Veterans' Affairs, House of Representatives, excluding the VA from futher participation in this program.

5. The VA fully agrees with the premise that further energy service pilot projects are not required; however, the VA is always willing to investigate other alternative energy conservation initiatives.

B. ENERGY MANAGEMENT PROGRAM:

- Executive Order 12003 established a goal of 20% reduction in energy consumption per square foot per year, in existing buildings by FY 1985 as compared to the FY 1975 base year. The VA had an actual reduction of 21.04% thus exceeding our goal.
- In 1985, Executive Order 12003 was extended for an additional ten year period and requires that an additional 10% reduction in energy consumption be achieved by FY 1995 when compared to the FY 1985 base year.
- Since FY 1985, the energy conservation and retrofit program and capital equipment program has invested, through the non-recurring maintenance program, the following amounts:

FY 86	$ 11.5 Million
FY 87	$ 9.5 Million
FY 88	$ 9.8 Million
FY 89	$ 5.4 Million

Funding was approved only for those projects which had a savings to investment ratio greater than one.

- The results of these investments directly affected the fuel expenditures by completing various retrofit projects. Comparative years show the following total expenditures for various types of fuels:

FY 86	$207.5 Million
FY 87	$187.8 Million
FY 88	$192.8 Million

It should be noted that at the end of FY 1988 compared to FY 1985, the square footage of the VA had increased by 5.04% and the air conditioning tonnage had increased by 16.0%. Also, the electrical consumption went up by 15% due to the installation of medical equipment for modern care. However as the retrofit investment decreases, we must anticipate an increase in fuel expenditures. A quick overview of investment to savings from FY 1975 through FY 88 is $161 million invested, $322 million saved.

- The savings indicated above have been the result of the following types of investments:

1. Over 100 energy management systems have been installed to provide:

    - Computerized control over HVAC/chillers, etc.
    - Monitors weather changes/adjusts accordingly
    - Trouble shoots maintenance problems
    - In some VAMCs also monitors smoke control, fire alarms and security systems

2. Converting from systems which use 100% outside air to variable air volume systems which are responsive to load changes in rooms in terms of amount of air required to be supplied to maintain design conditions.

3.
    - Insulation in attic areas
    - Heat recovery systems
    - Lighting reflectors and electronic ballasts
    - Variable speed controllers for pumps, fans
    - High efficiency motors
    - Voltage controllers
    - Go-generation plant (San Diego)
    - Solar Screens

4. The VA spent $76,000 for a consultant study to audit energy consumption at VAMC Durham, NC. This study will do the following:

  - Measure energy consumption for each VAMC system
  - Recommend corrections including estimated costs and savings for new capital equipment
  - Issue final Report

- The improved Energy Conservation Policy Act of 1988, signed in November 1988 by the President, allows all savings realized as a result of energy conservation may be retained by the Department and used to either further energy conservation or for any other authorized use. It also requires that funds to be used for energy conservation be a separate line item in the Budget beginning in FY 1990.

- The VA's energy conservation program received public recognition in FY 1988 by receiving two organizational and one individual national energy efficiency awards given by the Department of Energy for excellence in energy conservation at our medical centers.

- The VA is convinced that through the above energy conservation program, the most practical and economical approach is being followed. The savings realized will further reduce the VA's day-to-day cost of operating the medical centers. Consequently, the VA can utilize these savings to enhance our ability to provide the highest level of care to the veterans.

Department of Medicine
and Surgery
Washington D.C. 20420

Veterans
Administration

FEB 16 1989

In Reply Refer To: 10BA3

Honorable G. V. "Sonny" Montgomery
Chairman
Committee on Veterans' Affairs
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

This is in response to questions raised by Congressman Hammerschmidt and yourself during the VA Construction Hearings on February 1, 1989, concerning plans for construction of Spinal Cord Injury (SCI) beds in Florida and the decision to not activate SCI beds at the Gainesville VA Medical Center.

The history of our SCI planning efforts in Florida dates back several years to the activation of the 41 bed SCI unit at Tampa in 1971. Until 1983, a project had been in process to expand SCI capabilities at Tampa. In early 1983, a decision was made to combine the SCI project with a clinical addition project at Tampa to provide needed clinical support activities in one project. The project, however, continued to be delayed because of other agency-wide construction priorities. Problems were also encountered in acquiring necessary land for expansion. These land purchase difficulties, including legal proceedings relative to obtaining clear property titles, continued until purchase of a tract of land in 1985.

Throughout this time period the planned scope for expansion at Tampa varied with consideration given to activating SCI units at both Gainesville and Bay Pines. This was in response to a PVA request in late 1984. In early 1985, a decision was made to site 80 beds at Tampa and to also activate a new 30 bed SCI unit in Gainesville. This was a change to our previous plans to site a 100 bed SCI unit at Tampa and appeared to offer the advantage of having SCI beds more geographically dispersed. In early 1988, we re-examined this strategy, as reflected in the 1988 Strategic MEDIPP Plan, and determined that returning to our original planned expansion of 100 SCI beds at Tampa would provide the service in an area where the largest population of SCI veterans currently resides. This change is also supported by the action that the Tampa VA Medical Center has taken since 1985 in converting hospital beds to bring their SCI operating beds to a current level of 70. This action was necessary, as an interim measure, to keep pace with the growing demand for SCI care in the Tampa area. The above, coupled with Tampa's role as one of the VA's few designated Comprehensive Rehabilitation Centers influenced our decision. An additional consideration was the fact that the Gainesville SCI project had been included as part of a Nursing Home Care Unit expansion project and nursing home construction has not recently experienced strong support. As you recall, I notified you and the Chairman of the Senate Veterans' Affairs Committee of this change in a letter dated September 27, 1988. A copy is enclosed.

At the present time, the Tampa Clinical Addition project, which includes the SCI unit, is scheduled for design in FY 1991 and construction in FY 1992.

In closing, I appreciate your continued support of veterans.

Sincerely,

Arthur J. Lewis, MD
For JOHN A. GRONVALL, M.D.
Chief Medical Director

Enclosure

OPENING REMARKS OF
HONORABLE CHRIS SMITH, NJ
VETERANS' AFFAIRS SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
PROPOSED FY 1990 VA CONSTRUCTION BUDGET
FEBRUARY 1, 1989

Thank you Mr. Chairman.

Mr. Chairman, I appreciate your efforts to set up this hearing and I welcome the opportunity to discuss with representatives of the VA their progress and plans regarding medical construction projects.

There are many areas throughout the country in need of expanded or improved veterans' health care facilites. In an attempt to prioritize these demands, the VA has reviewed the physical conditions of various VAMCs and has rated them according to their need for repair.

According to the VA's own assessment, the Lyons, NJ VAMC requires renovation within the next 2-3 years in order to ensure adequate functioning of the building. The Lyons VAMC is in violation of national accreditation requirements, fire codes, and the VA's own standards. At this facility, some veterans in psychiatric wards are forced to live and bath in congregate settings with little or no privacy. This is certainly not conducive to the delivery of quality health care. Therefore, I was pleased to see a request for $13,700,000 in the FY 1990 budget request to help restore some of these existing deficiencies.

A similar situation also exists at the East Orange, NJ VAMC. The facility is in violation of several safety codes; and employees have been conducting medical research out of trailers. The VA has requested $3,100,000 to award a construction contract for renovations to remedy this situation.

Just last year, a lease contract was awarded for an outpatient clinic in Ocean County, NJ. Due to several delays in the project, it is unlikely that the clinic will open its doors in August, 1989, as originally scheduled by the VA. Though I have been informed that funding does exist in FY 1988 for leasing and activation of the clinic, I am interested to learn the funding status of the clinic throughout FY 1990.

Mr. Chairman, as we explore methods to make employment at VAMCs attractive to nurses, doctors, therapists, and pharmacists, we must keep in mind the importance of a physically appealing work environment. The physical settings at East Orange and Lyons, NJ offer limited appeal to potential employees. This must be changed if we are to achieve adequate recruitment and retention of personnel. Additionally, we owe our veterans safe health care facilities suitable for the delivery of quality health care.

Mr. Chairman, I look forward to further exploring these issues with our witnesses from the VA and am eager to hear the views of the veterans groups here today.

STATEMENT OF: Mr. Daniel I. Swedberg
Senior Associate
Booz, Allen & Hamilton, Inc.

SUBJECT: EVALUATION OF FOUR PILOT FACILITY DEVELOPMENT (FDP) PLANS

Mr. Chairman and Members of the Subcommittee:

I am pleased to appear before you today to discuss the results of our evaluation of the four pilot Facility Development Plans (FDPs).

Booz, Allen's evaluation of the pilot FDPs was started in April 1988. It was conducted in two phases: the first phase limited to the initial stage of the FDP process and the second phase focusing on the overall process. The first phase was completed in August 1988 and we are currently awaiting the VA's review of our overall evaluation report. My comments today are based on conclusions and recommendations contained in that report.

Our conclusion is that the pilot phase of FDP implementation has been a success. To understand that conclusion, it may be helpful to begin by explaining that the pilot FDPs were intended to accomplish two goals:

- To demonstrate a feasible approach for meeting objectives established for FDPs in the 1985 VA construction study that served as the impetus for this initiative

- To provide a way to identify and resolve problems related to cost-effectiveness before further implementation of the process.

Our findings demonstrate that both goals were accomplished.

The 1985 VA construction study defined three objectives for FDPs. FDPs were intended to provide information needed to (1) develop construction project plans, (2) justify and prioritize 5-year facility construction plans, and (3) coordinate current and future construction actions at the facility. Based on a review of the four pilot FDPs and interviews with over 100 people involved in or knowledgeable of the results of the pilot FDPs, we found that all four pilot FDPs accomplished their intended objectives. In other words, we found that the pilot approach represents a feasible way to accomplish objectives originally established for FDPs.

We also examined cost-effectiveness issues encountered in preparing the four pilot FDPs. Our primary purpose was to identify weaknesses in the pilot process and to determine if steps had been taken by the VA to resolve them in planning for full-scale implementation. A number of weaknesses were identified that reduced the efficiency of the pilot process and the quality of results received. However, we also identified actions that have been taken by the VA since the beginning of the pilots to address those weaknesses. They include numerous refinements in the FDP Statement of Task, explicit definitions of the responsibilities of various VA organizations involved in the process, preparation of guidance on standard FDP format, and a number of other actions. As a result, the process the VA is now using for full-scale implementation is significantly improved from the process used to prepare the pilot FDPs. Therefore, the pilot implementation was successful in identifying and resolving issues related to cost-effectiveness.

Because of this, we recommend that the VA continue with full-scale preparation of FDPs at remaining VA Medical Centers. We believe the VA's goal should be to complete FDPs at remaining medical centers over the next three years. Our report identifies two refinements, in addition to those already implemented by the VA, that should be considered for implementation in the full-scale FDP process.

In addition, we recommend that the VA focus attention on other aspects of the FDP program that will determine its ultimate success. One of those is the development of procedures and systems for updating and revising FDPs on an on-going basis. The on-going maintenance of FDPs is an important issue for the future viability of the program.

Another issue that should be addressed is the impact of FDPs on VA national construction planning. The 1985 VA construction study identified opportunities for improvement in national construction planning that could also be achieved once FDPs were completed. We believe that the VA should begin now to determine the requirements of an integrated database that uses FDP data to improve national construction planning. Their goal should be to complete those improvements within the next three years.

In summary, we believe that the VA is on the right path for making significant improvements in planning for its health care facilities. The preparation of facility development plans at VA medical centers is an important first step in providing information needed to ensure that construction dollars are spent wisely.

STATEMENT BY REP. JAMES H. BILBRAY

MR. CHAIRMAN, I WANT TO THANK YOU FOR ALLOWING ME TO TESTIFY BEFORE THE SUBCOMMITTEE TODAY ON YOUR REVIEW OF THE VETERANS' ADMINISTRATION (VA) CONSTRUCTION BUDGET FOR HOSPITALS AND NURSING HOMES.

AS THIS COMMITTEE HAS SEEN, THOUSANDS OF VETERANS ACROSS THE COUNTRY ARE BEING TURNED AWAY FROM ADEQUATE HEALTH CARE. THE VETERANS ADMINISTRATION, IN RECENT MONTHS, HAS BEGUN TO TERMINATE HEALTH CARE PROGRAMS, TAKE HOSPITAL BEDS OUT OF SERVICE AND DENY TO CERTAIN GROUPS OF VETERANS CARE AT VIRTUALLY EVERY VETERANS' HOSPITAL IN THE COUNTRY.

THIS ALARMING TREND WILL SURELY GET WORSE AS WE SEE A MEDICAL BUDGET SHORTFALL OVER THE NEXT TWO YEARS OF $1.1 BILLION BELOW THE AMOUNT NEEDED TO DELIVER THE LEVEL OF HEALTH CARE SERVICE PROVIDED IN FISCAL YEAR 1988.

MR. CHAIRMAN, CURRENTLY IN NEVADA, VETERANS WHO NEED IN-PATIENT MEDICAL CARE MUST TURN TO THE NEAREST VA HOSPITALS WHICH ARE IN LOMA LINDA, CALIFORNIA, ABOUT 350 MILES AWAY, AND IN RENO, NEVADA, ABOUT 400 MILES AWAY.

THE ABSENCE OF A LOCAL VETERANS HOSPITAL HAS BEEN A HARDSHIP FOR MANY OF THE MORE THAN 100,000 VETERANS IN SOUTHERN NEVADA. IN 1988, THE VA OUTPATIENT CLINIC IN LAS VEGAS, WHICH DOES NOT PROVIDE HOSPITAL CARE, REFERRED OR TRANSFERRED TO THE VA HOSPITAL IN SOUTHERN CALIFORNIA 1,882 PATIENTS. AND ALL THE INDICATIONS ARE THAT THIS PROBLEM WILL ONLY GROW. SOUTHERN NEVADA HAS BECOME A FAVORITE RETIREMENT COMMUNITY AND DEVELOPERS HAVE ON THE DRAWING BOARDS NEW COMMUNITIES WHICH ARE DESIGNED TO ATTRACT MORE NEW SENIORS, MANY OF WHOM WILL BE VETERANS.

AS IN MANY CASES, FAMILIES OF VETERANS ARE UNABLE TO GET TO SOUTHERN CALIFORNIA TO VISIT THEIR LOVED ONES, AND THAT HAS BEEN BOTH A FINANCIAL TOLL OF TRAVELING AND AN EMOTIONAL TOLL OF BEING AWAY DURING A TRAUMATIC TIME IN A FAMILY'S LIFE.

SINCE 1982, THEN REPRESENTATIVE HARRY REID, NOW THE SENIOR SENATOR FROM NEVADA, HAS BEEN WORKING ON GETTING SUPPORT FOR A JOINT VETERANS ADMINISTRATION/DEPARTMENT OF DEFENSE HOSPITAL TO BE BUILT AT NELLIS AIR FORCE BASE.

ORIGINALLY SCHEDULED FOR FISCAL YEAR 1989, THE DEPARTMENT OF DEFENSE MOVED THE STARTUP DATE TO FISCAL YEAR 1991. THROUGH MUCH HARD WORK AND PERSISTENCE, THAT DATE HAS BEEN MOVED BACK UP TO FISCAL YEAR 1990.

IN THE BUDGET SUBMITTED TO CONGRESS JANUARY 9TH, THE AIR FORCE REQUESTED $62 MILLION FOR ITS SHARE OF THE COST. THE VA ASKED FOR $9.3 MILLION FOR A TOTAL OF $71.3 MILLION.

OF THE 128 BEDS, 52 WOULD BE ALLOCATED FOR VETERANS AND 76 TO THE DEPARTMENT OF DEFENSE.

THE HOSPITAL IS TO BE OPERATED AS A TRULY INTEGRATED FACILITY (I.E., NO SEPARATE WARDS WILL BE PROVIDED FOR DOD OR FOR VA PATIENTS). WITH THE AVERAGE SHORT-TERM VETERANS INPATIENT STAY AVERAGING JUST OVER 13 DAYS, THE HEALTH NEEDS OF UP TO 2,000 VETERANS CAN REASONABLY BE PROVIDED FOR AT THE FACILITY EACH YEAR.

IN A WORLD WITHOUT MASSIVE FEDERAL DEFICITS I WOULD PROBABLY BE ASKING THE COMMITTEE TO CONSIDER BUILDING SEPARATE FACILITIES FOR SOUTHERN NEVADA'S VETERANS AND ACTIVE DUTY MILITARY PERSONNEL AND THEIR DEPENDENTS. BUT, WE DO HAVE A MASSIVE FEDERAL DEFICIT, AND THE FUNDS ARE SIMPLY NOT AVAILABLE TO BUILD TWO HOSPITALS.

THIS JOINT EFFORT IS A CREATIVE WAY OF DEALING WITH THE HEALTH NEEDS OF VETERANS AND FUTURE VETERANS. MY CONVERSATIONS WITH THE PEOPLE AT NELLIS AND IN THE VETERAN COMMUNITY INDICATE TO ME THAT THERE IS A WILLINGNESS TO MAKE THIS JOINT SOLUTION WORK.

MR. CHAIRMAN, IN THE PAST TWO YEARS, I WAS FORTUNATE TO WORK WITH LOCAL VETERANS, AND NEVADA STATE OFFICIALS TO CREATE A STATE VETERANS' CEMETERY IN SOUTHERN NEVADA. IN A SPEECH BEFORE A JOINT SESSION OF THE NEVADA LEGISLATURE, I SPOKE OF THE VETERANS WHO GOT VERY LITTLE PAY AND GAVE UP YEARS OF THEIR LIVES FOR THEIR COUNTRY. ALL THEY ARE ASKING FOR IS WHAT IS RIGHTFULLY THEIRS. WE MUST NEVER FORGET THEM.

I URGE THE SUBCOMMITTEE'S SUPPORT FOR THE VA HOSPITAL AT NELLIS. THANK YOU.

Statement of

NOEL C. WOOSLEY

AMVETS National Service Director

Before The

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

On

PROPOSED FY 1990 CONSTRUCTION BUDGET

Wednesday, February 1, 1989

9:00 a.m., Room 334

Cannon House Office Building

Mr. Chairman, members of the Committee, AMVETS thanks you for this opportunity to testify with respect to the Administration's proposed FY 1990 construction budget for the Veterans' Administration soon to be known as the Department of Veterans' Affairs.

At the outset, let me state that we find the Administration's proposed budget, as pertains to construction, not only inadequate but unrealistic. We base this on the fact that as the aging process of America's veterans continues to be spotlighted as a primary concern, there is little if any evidence that this same aging process is of any concern with respect to VA facilities.

In the area of new construction the proposed three new outpatient clinics would appear to contradict the current medical methodology of outpatient treatment in order to obviate the need for hospitalization. While the need for outpatient clinics (OPC) will vary greatly based on the demographics of an ever changing veteran population, it is not at all difficult to target several states where the presence of an increased number of OPCs may be the only way for the VA to keep the promise.

> To illustrate, the Secretary of Labor's Committee on Veterans Employment, in a report soon to be released, estimates that as of March 31, 1988 the veteran population of the United States and Puerto Rico was 27,359,000. Seventy eight percent of all living veterans had war time service, but more over the report shows that nearly half of all living veterans are located in eight states.

	Total
California	2,826,000
New York	1,843,000
Texas	1,787,000
Pennsylvania	1,515,000

Florida	1,484,000
Ohio	1,293,000
Illinois	1,242,000
Michigan	1,014,000

With the projected two new nursing homes and the conversion of hospital beds to nursing home care beds; the Administration's proposed budget shows an increase of 1,035 nursing home care beds for FY 1990. At the same time this budget proposes a cut in VA domiciliary beds of 3,475 (granted domiciliary beds are not nursing care beds, however they could easily be converted as opposed to eliminated.) There is also a projected loss of 3,449 community nursing home beds. This would in fact appear to be a loss of 5,889 potential nursing home care beds during a time when all the studies point to an ever increasing need for these facilities.

> Once again to illustrate, using information from the above mentioned report, there are currently over 1.1 million veterans 75 years of age and older. There are 126,000 World War I veterans with a median age of 91 and 9,606,000 World War II veterans with a median age of 66.

The adoption of the Administration's budget, as proposed, would set the entire VA medical delivery system on a rapid course to extinction and those proponents of privatization would be the eventual winners.

As you are aware Mr. Chairman, AMVETS, the Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars have once again cooperated in an effort to address the needs of America's veterans based on moral as well as legal obligations this nation has deemed as just and befitting those men and women who chose to answer duties call. Thus, for the third consecutive year we have produced an independent budget by veterans, for veterans. With the knowledge that each member of this Committee has a copy of the proposed independent budget, I should like to point out that for the purpose of this hearing we totally support the construction program principles and guidelines as outlined in said document. We feel that the recommendations, strategies and overall development in respect to the VA's minimum construction needs were factually based and realistically spelled out. We respectfully request that each of the members of this Committee review the independent budget and give careful consideration to the proposed funding levels contained therein.

This concludes my statement and again AMVETS thanks you for this opportunity.

TESTIMONY

COLONEL HERB ROSENBLEETH, U.S. ARMY (RET)

NATIONAL LEGISLATIVE DIRECTOR

JEWISH WAR VETERANS OF THE UNITED STATES OF AMERICA

BEFORE THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

February 1, 1989

Chairman Montgomery and Members of the Subcommittee on Compensation, Hospitals and Health Care of the House Veterans' Affairs Committee, I am Colonel Herb Rosenbleeth, US Army (Ret), the National Legislative Director of the Jewish War Veterans of the United States of America, a congressionally chartered veterans' service organization. On behalf of our membership, I thank you for the opportunity to appear today to testify before this distinguished committee.

Since it's founding in 1896, the Jewish War Veterans of the USA, the oldest active veterans' organization in the United States, has stood for a strong national defense and for just recognition and compensation for veterans. JWV is a voice for America's security interests around the world and it has always been a supporter of human rights issues.

Mr. Chairman, JWV strongly believes that the VA needs to update and repair many, if not most, of its medical centers. Electrical, heating and plumbing systems, and equipment are in dire need of modernization throughout the VA health care system.

The VA needs to construct at least four new 120-bed nursing homes each year and convert current VA hospital beds to nursing home beds on a programmed basis. The estimated cost of four nursing homes is $30 million per year and the cost of converting an adequate number of VA hospital beds, is approximately $20 million per year. The VA needs to speed up construction projects, reducing the time from initial planning of projects to their completion.

JWV concurs with the FY 90 request for $112 million for the building of a new VA facility at Palm Beach, Florida and with the $53.7 million for modernization of the VA Medical Center in Newington, Connecticut. It must be noted, in fact emphasized, that the proposed facility in Palm Beach is the first medical center to be added to the VA system since the mid-1970's and that the Florida area has an urgent need for many more VA beds. JWV also concurs in the requested $10.7 million for the renovation of certain buildings at the VA medical center in Lyons, New Jersey, and the $6 million in design funds requested for the seismic project at the VAMC in Long Beach, California.

In a climate of ever increasing health care costs and an expanding federal budget deficit, the Congress has instituted measures to ensure close cooperation between the Veterans Administration and the Department of Defense (DoD) in all new health care facilities construction.

As you know, Public Law 97-174 (May 4, 1982) is the keystone legislation which supports a wide range of health resources sharing between the VA and the DoD. More specific legislation to encourage VA-DoD Joint Venture hospital construction soon followed. PL 99-579 (October 28, 1986) directed the Administrator of the VA to "give consideration to sharing with the DoD the cost of any new construction, alteration or acquisition of a medical facility which involves a total expenditure of more than $2 million". Further, the Military Construction appropriation Act (FY 87/88) directed that the DoD "will not proceed with design of new hospitals in the U.S. until all possibilities of shared use with the Veterans Administration are fully explored.

Currently, six VA-DoD Joint Venture Construction projects are in various stages of development:

1. Albuquerque, NM - Since June 1987 U.S. Air Force medical personnel have operated a forty bed unit on the 6th floor of the new VAMC. The VA provides all ancillary support to the in-house Air Force staff, including nuclear medicine, pharmacy, dietetics, and housekeeping. The Air Force reimburses the VA for this assistance. On the other hand, the hospital emergency room is under the supervision of an Air Force medical officer and is jointly staffed by VA and Air Force personnel. Also, a new Air Force outpatient clinic is being constructed adjacent to the VAMC on VA property. The new clinic is scheduled for beneficial occupancy in April 1989. A common, covered walk-way will connect the Air Force Clinic to the VAMC.

2. Las Vegas, NV - The VA agreed to share in the construction cost of a new Nellis Air Force Base Hospital and the Air Force has agreed to designate 52 of the planned 135 beds for VA patients. Currently, the VA has no hospital in the Las Vegas area. construction is scheduled to start in FY 1990 and the new Air Force/VA hospital will be completed in FY 1993.

3. Anchorage, AK - The Air Force will initiate a complete renovation of its Elmendorf USAF Base hospital, Anchorage, Alaska. The VA, having no hospital in Alaska, has agreed to share in the construction costs for the renovation in order to secure 18 of the proposed 112 beds for VA patients. Construction will begin in FY 1992 and be completed in FY 1995.

4. Tucson, AZ - The USAF has signed an agreement of intent to explore the feasibility of sharing in the construction of the newly planned Veterans Administration Medical Center in Tucson. The VA must replace its 60 year old bed building and the Air Force must vacate its existing, inadequate, Davis-Monthan Hospital. Consequently, the mutual benefits and cost savings of joint venture construction are being closely scrutinized. The hospital construction start-date is scheduled for FY 1992.

5. El Paso, TX - The Army has designated 105 inpatient beds for VA beneficiaries in the William Beaumont Medical Center. The VA and Army are not negotiation a joining construction venture for a new outpatient clinic facility to be affiliated with the Army Medical Center. The facility will be constructed by the VA on the William Beaumont Campus. The Army physicians will share in the use of ambulatory surgery suites in the clinic and will be available to perform surgery on VA patients. The construction start-date is scheduled for FY 1992.

6. Lawton, OK - In FY 1991 the Va will start construction of a new outpatient clinic adjacent to the new U.S. Army Hospital at Ft. Sill. The Army has agreed to provide the land, common utilities, and parking area for the VA clinic. Also, the Army will provide inpatient services the VA beneficiaries on a reimbursement bases. The VA clinic, on the other hand, will provide some radiology services for the Army medical staff. The VA clinic will be connected to the Army Hospital by a common, covered walkway.

In addition to the above, VA and the DoD are exploring the potential for other joint venture projects in: East Central FL, Spokane, WA, Philadelphia, PA and Lubbock, TX.

In view of the pressure of the federal deficit, and the enormous expense of medical facility construction and maintenance, JWV urges the VA to strengthen its participation in the Health Care Resources Sharing Program with DoD.

JWV commends the members of the VA Central Office who have been managing this important program, and who have achieved the results described above. These results will be reduced construction costs to the VA and increased access to services for veterans.

The Jewish War Veterans of the USA appreciates being able to appear before this subcommittee on this extremely important legislative issues. We are grateful to Chairman Montgomery and to this subcommittee for your efforts in support of America's veterans.

STATEMENT OF

ROBERT MANHAN, SPECIAL ASSISTANT
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

FISCAL YEAR 1990 CONSTRUCTION BUDGET FOR THE VETERANS ADMINISTRATION

WASHINGTON, D. C.
FEBRUARY 1, 1989

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

Thank you for the opportunity to present the views of the Veterans of Foreign Wars with respect to the Veterans Administration's construction program for Fiscal Year 1990. We share the Subcommittee's continuing interest in this subject because of the direct impact it has on our nation's veterans and their families. In fact, there was so much concern expressed by our 2.2 million members at our last National Convention regarding facilities and construction that two of our 11 priority legislative goals for 1989 deal specifically with these very mundane but significant problems. The VFW resolved to ask Congress to provide an adequate annual funding level to allow the VA to now plan and initiate new construction efforts to meet the immediate future needs of veterans; and, to provide our nation's veterans with an open national cemetery in every state.

As you recall, the Veterans of Foreign Wars again this year joined AMVETS, Disabled American Veterans and Paralyzed Veterans of America in presenting to the Congress an independent budget for the Veterans Administration, the FY 1990 Independent Budget (IB). Our collective intent is to cooperate with the Veterans Administration to make the best use of available dollars. Together we must create an annual budget driven by some key principles that are shaped by our clients. We know we will have more veterans living longer; we know we have newer medical procedures and medicines available to improve the quality of their lives and we know we have significant changing demographic factors. Based on these realities, the Veterans of Foreign Wars believes that by applying some creative thinking and exercising some intelligent leadership the veteran community can achieve a more meaningful, modern series of facilities that are, in fact, more than a veteran's commodity but rather a national good. It is this view we would like Congress to appreciate when it is time to vote the Veterans Administration's FY 1990 budget.

Based on the above philosophy the Veterans of Foreign Wars recommends a $922 million construction program appropriation for FY 1990. Our total sum is almost twice the $501 million reflected in the President's FY 1990 Department of Veterans Affairs budget dated January 1989. Of course, this document was influenced to an unknown degree by the Office of Management and Budget (OMB). We believe about $635 million should be used for major construction and $275 million be used for minor construction with $12 million earmarked for the relatively new Revolving Fund Parking Garage Program. In our judgment, this parking charge smacks of a "user fee" approach to the greater problem of obtaining convenient and more prompt service throughout the VA system.

The lion's share of our major construction monies, some $559 million, should be used as stated in the Veterans Administration's construction requirements cited in their own "Five-Year Medical Facility Development Plan for FY 1990", published in August 1988. We strongly believe much more monies should be available this year for the rehabilitation center and canteen at the Salt Lake City, Utah Medical Center; that there is still a valid requirement for the clinical addition to the Wilmington, Delaware Medical Center and a new psychiatric building in Columbia, South Carolina's Medical Center as well as the need to repair and otherwise correct the structural seismic deficiencies at the Long Beach, California Medical Center. As previously stated, these and other medical center construction projects were considered as a high priority by the VA as recently as seven months ago. We also hasten to add that lacking an in-depth analysis of national construction requirements, that these funds should be dedicated for FY 1990 in view of the very lengthy time involved in the current building replacement and/or improvement cycle, the changing clinical requirements, and the age of the current plant in general.

The next largest recommended appropriation is $40 million for the Advance Planning Fund and Design Fund. The purpose of these two closely related funds is to allow projects to proceed in an expeditious and cost effective manner through the planning and design stages of the construction process. This represents some $15 million more than the approximate $25 million the VA has requested. We believe ours is a more rational figure to begin to accelerate the historically lethargic ten year construction process. This strategy of a strong early effort for planning and design at the beginning of the construction "pipeline" will support and accelerate rapid expansion of the overall volume of needed major construction projects once the VA's process for national construction prioritization has been developed, and also when greater sums of money can be forthcoming from the Congress. For the real cost just begins with the pouring of cement and continues through to the equipping and furnishing of the structure itself.

Our next major construction program deals with nursing homes. This is a very significant item and we believe $30 million is the absolute minimum required to fund four new facilities of 120 beds each. As you recall, the primary mission of nursing home facilities is to provide care to veterans who have chronic conditions requiring care but who are not in need of hospital treatment. We believe the expanding segment of the "old-old" veteran population, those 75 and older, will require such facilities. Accordingly, we can foresee a need to build four new VA nursing homes each year for the next several years of this coming decade. This must be done in conjunction with the earlier request of the Veterans of Foreign Wars to have the VA convert 1,000 existing hospital beds to nursing home use each and every year through the 1990s starting with a one-time conversion of about 2,000 such beds to this purpose beginning in FY 1990 which will start on October 1, 1989. Based on the above discussion of the lack of nursing home facilities, we believe the VA's requested $2 million for FY 1990 is woefully inadequate.

Our last major construction appropriation is for $6 million to be spent for purchase of land for new national cemeteries in the eight states that currently have no such facility. They are Washington, Idaho, Nevada, Montana, Wyoming, North Dakota, Vermont, and New Hampshire. We believe the VA should budget enough money each of the next four years to add two new national cemeteries annually until the National Cemetery System has met our minimum goal for having available grave site space in every state. Our eventual goal is to have a usable national cemetery within reasonable distance of each of the nation's major veteran population centers.

A primary intent of the $275 million of minor construction monies is to ensure that the entire VA system is maintained in a good state of repair. Tasks range from moderizing the functional space in a regional office to renovating facilities in health care delivery rooms to accommodate technologically advanced equipment.

Of this above total, $200 million is identified for medical construction minor projects, with $40 million specifically set-aside for the conversion of existing medical center space to nursing home use exclusively. This estimated $40 million should be sufficient to permit the conversion of the previously mentioned 2,000 bed spaces to nursing home care in this fiscal year. The reason for this one-time conversion of 2,000 bed spaces is to reinforce our concern that the 1,000 bed conversion recommended in the FY 1989 IB was, in fact, not accomplished. As you recall in our discussion of major construction, it is our judgment that to convert about 1,000 VA hospital beds to nursing home use each year for the next seven to nine years is imperative. This is one significant area of professional difference wherein we believe the future has been badly underrepresented in the VA budgetary process for the past few years. This set-aside of at least $20 million annually for conversion, with the FY 1990 $40 million, is an attempt to resolve the VA's past argument that it was a lack of construction funds that prevented their initiation of this needed bed conversion project. In concluding our case for beginning to establish an adequate national nursing home care program for our nation's veterans, we hold that any rationale to turn this effort over to the various states as had been mentioned, creates the reductio ad absurdum of requiring states to provide for their own military defense. This issue was resolved over 200 years ago when our Constitution was ratified. In fact, this criticism highlights the importance the VFW places on the matching grant programs extended to the respective states through the VA to ensure a uniformly high degree of excellence within the nursing home field. Therefore, the VA's requested \$2 million for minor construction projects for nursing home care should be an area of real concern to be resolved this year.

We propose to almost double the funds needed this year for reasonable amounts of money required to support priority minor construction projects in the VA's Regional Offices (VAROs) and in existing National Cemeteries. This rationale is supported in our FY 1990 IB projections of \$5 million and \$10 million respectively for VAROs and cemeteries. To do any less regarding office buildings that are an average of about 40 years old is to be "penny-wise and pound-foolish". Or said another way, in the short run it will cost more money just to maintain the present state of obsolesce and shabbiness.

The last appropriation of \$60 million in minor construction funds is to be spent for that portion of the VA staff that oversees the entire construction process; primarily, the Office of Facilities. Our overriding concern is to maintain the Office of Facilities at least at current manning levels and to allow the VA to take steps to initiate now a formal institutional process that will define construction priorities in terms of nationwide construction strategy. In point of fact, the Veterans Administration had commissioned several major studies to examine its current construction process. We accept this initial action, but we believe it is now time to address the systemic problems that have been identified. The most obvious one being the excessive time required to complete construction projects. Appendix D of the FY 1990 IB is devoted exclusively to the recognized problems in the VA's construction program philosophy.

Last, we propose \$12 million be appropriated for the Parking Garage Revolving Fund. This is some \$5 million greater than the \$7 million the VA has asked for in new budget authority for Palm Beach, Florida. We recognize the Parking Garage Revolving Fund is a relatively recently established appropriation. When the fund is fully established, revenues from the parking garages which it has financed will at least partially pay for needed additional parking facility projects. Because this particular fund is in a start-up mode, and because reasonable access to medical treatment is an essential element of the treatment process itself, especially with an aging veteran population, we believe it is essential to "prime the pump" now to start the revolving fund flowing and to provide the needed parking.

Mr. Chairman, this concludes my testimony and I will be happy to respond to any questions you may have.

STATEMENT OF
GORDON H. MANSFIELD, ASSOCIATE EXECUTIVE DIRECTOR
FOR GOVERNMENT RELATIONS
PARALYZED VETERANS OF AMERICA
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
REGARDING
THE PROPOSED FISCAL YEAR 1990
VETERANS ADMINISTRATION CONSTRUCTION BUDGET
VA FACILITY DEVELOPMENT PLANS
SPINAL CORD INJURY UNITS
OUTPATIENT CARE FACILITIES
FEBRUARY 1, 1989

Mr. Chairman and Members of the Subcommittee, Paralyzed Veterans of America appreciates this opportunity to express our views on the Reagan Administration's proposed Fiscal Year 1990 Construction Budget for the Veterans Administration (VA), the VA Construction Facility Development Planning Process (FDP), and the vital importance of VA Spinal Cord Injury Center Construction.

On behalf of the membership of Paralyzed Veterans of America allow me first to express our congratulations and best wishes to you, Mr. Chairman, the Members of this Subcommittee and the Full House Committee on Veterans' Affairs as you begin the important work of the 101st Congress. You face an intricate challenge, working with a new Administration and a new Secretary for the Department of Veterans Affairs. At the same time, you face again the chronic problem of increasing veteran demand for services, federal budget deficits, and an alarming funding shortfall for the VA. Hopefully, in the spirit of cooperation expressed by President Bush, the Congress and the Administration, working together, can find equitable funding solutions to help meet the needs of those who have served in defense of this Nation. We extend our offer of support and full cooperation to assist you in this process in any way we can.

The construction needs of the VA for maintenance, repair and replacement of facilities are perhaps the most visible indicator of the desperate condition the VA is in. Quality modern health-care demands an up-to-date and state-of-the-art setting.

VA health care facilities are aging at a far greater rate than the veteran population itself. Funding for both major and minor construction has not kept pace with this deterioration. This continuing erosion severely restricts the quantity of health care available and severely endangers the quality of medical services provided to the veteran community. Overall, the VA's construction program is faced with the following problems.

- The agency's construction priorities are basically dollar driven and dollar restricted without regard to any proper long-term planning process.

- There is no sound, effective or utilitarian process for proper facility development and improvement. The proposed VA Facility Development Planning process costing at VA estimates a minimum of $40 million to implement over the next several years is severely flawed. The Medical District Initiated Planning Process (MEDIPP) is unwieldy and awkward, failing to give accurate projections of national VA needs.

- The VA's Office of Facilities supports a staff of approximately 800 employees and yet major construction projects typically take 10 years from conception to completion. Comparable projects in the private sector take three to four years to complete.

- There has been a systematic history of major errors and flaws in the construction process at great expense to the taxpayer and inconvenience to the veteran. Without adequate or consistent planning, millions of dollars have been spent to design buildings never built or to redesign facilities based on erratic utilization data or ever-tightening budget squeezes.
- The VA has turned a blind eye to the crucial long term care needs of the aging veteran population. The agency restricts funding for home health care alternatives on the one hand and proposes no new nursing home construction for next year on the other. Proper plans to convert existing unused hospital beds to nursing care beds are more promises than reality in this budget as in past budgets. The VA does not even call for the funds to activate the new nursing homes that are coming on line this year.
- The current Office of Management and Budget (OMB) policy only allows the VA to contract for two major clinical additions, replacements, or top-to-bottom renovations per year. At this rate, the VA is on an 86-year replacement cycle for its 172 hospitals.

The VA is requesting $480.448 million in major and minor construction for FY 1990. The major construction proposal, $365.849 million, is virtually identical to this year's funding level and $37 million below FY 1988 spending. The FY 1990 minor construction appropriation request, $114.699 million, is practically at the same level as FY 1988 and FY 1989. Proposed outlays for minor construction would drop $31.415 million if this budget is approved. We find these funding levels wholly inadequate to meet the needs of the VA system.

PVA has endorsed construction funding levels proposed by the "Independent Budget By Veterans for Veterans' Programs." For the third year in a row we have worked with AMVETS, Disabled American Veterans, and Veterans of Foreign Wars to design a comprehensive analysis of the VA's budget needs. This document, which took almost twelve months to produce, is based on the most up-to-date data from the VA and other sources available. A copy of the "Independent Budget" has been provided to every member of Congress. We encourage that you carefully review it. We have attached those chapters dealing with VA construction to this testimony.

The Independent Budget recommendation calls for total major and minor construction appropriations of approximately $922 million. This amount incorporates all of the construction needs projected for FY 1990 by the VA in its current Five-Year Medical Facility Development Plan. This budget figure is not only our recommendation. It is the projection by the VA itself of its own construction priorities. The plan details the urgent need to upgrade and improve scores of VA facilities to meet function and space requirements dictated by modern medical practice.

Spinal Cord Injury Centers

In 1944, at the close of World War II, the life expectancy of an individual who had suffered a catastrophic spinal cord injury was only 6 to 9 months. If a veteran survived the initial injury, he or she was at severe risk of grave systemic complications and infections secondary to that injury. The advent of sulfa drugs and improved antibiotics greatly improved the opportunity for post injury survival, stabilization, and rehabilitation.

The body of knowledge surrounding the treatment of spinal cord injury has grown slowly, but steadily, since that time. Today a spinal cord injured person has a life expectancy which approximates the rest of the American population. Current research efforts, such as those being conducted at PVA/EPVA-funded Center for Neuroscience and Regeneration Research of Yale University located on the grounds of the West Haven VA Medical Center, are currently making advances in curing spinal cord injury itself.

These achievements have been made because the medical community and the VA, in particular, realized that a catastrophic spinal cord injury, because of its massive alteration to physical condition, required a unique and highly specialized program of treatment, study and on-going long-term rehabilitation. Such expertise was not widely available in large part just twenty years ago. But even today, a person with a spinal cord injury cannot just go to any physician's office down the street or check into any hospital at random and be assured that the health care professionals there are fully trained in providing the very specialized form of SCI related diagnosis and care. SCI specialities embrace unique areas of a multidisciplinary approach to treatment involving neurology, urology, orthopedics, internal medicine, plastic surgery, mental health science, rehab medicine, physical therapy prosthetics and orthotics to name but a few.

Mr. Chairman, the VA has played an important role in the progress made in treating spinal cord injury and disease. The main reason for this achievement has been the development and expansion of the agency's spinal cord injury centers. As the map attached to my testimony indicates, there are now 21 SCI Centers in the VA health care system.

The SCI center plan was designed to develop a "center of excellence" concept for the specialized treatment of spinal cord injured veterans. The centers provide acute, intermediate and long term care. They also provide the resources and the opportunity to train and equip a whole cadre of health care professionals sensitive to the unique needs of SCI care, rehabilitation and research. Because of the catastrophic nature of their disabilities, PVA's members utilize VA health care services at a higher rate than perhaps any other group of veterans. The primary locus of their care is within the SCI Center network. For this reason we are understandably concerned about the maintenance and support which the VA provides to sustain SCI center operations.

PVA regularly conducts reviews of SCI center activities through our Department of Medical Affairs and Research. Our program of Architecture and Barrier Free Design closely monitors SCI center construction to insure that the unique health care demands of SCI patients are matched by appropriate physical space and design characteristics.

The average VA hospital ward is totally unsuited to provide adequate care for large numbers of wheelchair-bound or long-term bed-ridden spinal cord injured patients. For instance, a serious and potentially life-threatening skin breakdown, pressure sore or decubitus ulcer for an individual veteran often requires months of hospitalization, plastic surgery and rehabilitation. The design and construction of SCI facilities must be carefully crafted to pay careful attention to the specific and unique needs of these patients and the staff that cares for them. This is an exacting science, calling for more than just barrier-free design. An effective SCI center must insure certain additional standards of space and patient privacy in bedrooms, bathrooms, treatment and rehabilitation areas--even appropriate parking and access areas. All of these features have a direct bearing on the ability of the SCI center to provide adequate care and, ultimately, the health and well-being of the spinal cord injured veteran patient.

Proposed VA Spinal Cord Injury Units

The VA has developed a system-wide plan for the expansion of its SCI centers. We believe the agency should adhere to this schedule very closely. However, certain problems have arisen in the past several months which have put a halt to a major component of this process.

The VA has decided to eliminate a 30-bed SCI unit planned for Gainesville, Florida VAMC. Planning errors at the Dallas VAMC clinical addition and SCI center now threaten to delay that project for years. Both actions seriously endanger the provision of health care for spinal cord injured veterans in these catchment areas. These decisions are also indicative, and a result of, serious problems within the VA's construction planning process itself.

Dallas SCI Project

The FY 1989 appropriation contained $13 million in design funds for a major clinical addition, improvements and an SCI center with 30 acute care beds and 30 long term care beds. The preliminary design for this major project was completed in 1987 at a cost of $2 million. PVA has now been informed by the VA that the entire design, based on MEDIPP projections current just two years ago, will have to be completely revised and redrawn based on new 1988 MEDIPP projections. The new figures now show a 59 per cent increase in workload projections. The price for this re-design may be a million dollars or more. The change could delay the project for at least another year. We only have to wonder if the 1990 MEDIPP workload will change again as radically and if the new design will meet those standards then. In the meantime, $13 million provided for this project by the Congress will sit in escrow. Veterans in the Dallas area, including one of the largest concentrations of spinal cord injured veterans in the country without access to an SCI center, will have to go without specialized care in a modern treatment unit.

The problems here are twofold. First, if it takes the VA so long to design and prepare a project for funding, it is no wonder workload projections change by the time a new facility is ready for construction. Second, it is very clear to us, based on this example and other examples more fully described in the Independent Budget's VA construction section attached to this testimony, that the MEDIPP process itself is incapable of adequately reflecting and responding to projected veteran patient demand.

Undoubtedly, it would have been awkward for the VA and OMB to provide the full construction funding for this project in excess of $100 million, in FY 1990. These funds would normally flow following the $13 million in design funds provided for this year. We trust this was not a factor in the agency's decision to redesign and delay the project. We have asked the VA for a full explanation and status report on this matter.

It is not clear whether the changes in MEDIPP projections affect the SCI center design in the same fashion as the more major part of the project, the clinical addition. We encourage the Committee to review this situation to see if the SCI portion of the project could commence as the first phase of the entire project while awaiting redesign of the clinical addition.

Gainesville - Tampa, Florida, VAMC SCI Projects

The 1985 VA plan for Spinal Cord Injury Center Construction in Florida proposed the construction of a 30-bed SCI center (collocated with a new 120-bed nursing home) in Gainesville and an 80-bed unit in Tampa. The Gainesville project was scheduled to receive initial funding this year with completion in 1993. The Budget Resolution for FY 1989 approved by the House and Senate contained language supporting this project. The House Veterans Affairs Committee, last year, authorized the nursing home part of the project which was designed at a cost of $250,000. The nursing home is to be located in the new building on the two floors above the SCI unit. The Senate Veterans' Affairs Committee only authorized the SCI unit.

In September, 1988, the VA changed its mind and decided to eliminate the SCI center. If this decision stands, the VA would have to redesign and further delay the nursing home as well.

The VA's new plan is to shift 20 of the 30 Gainesville beds to the Tampa project. The design process hasn't even begun on the Tampa project (tentatively scheduled for completion in 1994). The VA recommends this change again based on fluctuations in MEDIPP data which were applied for the first time to SCI construction in 1988. We have asked the VA through the Freedom of Information Act to review this data.

Strangely, however, the letter to you, Mr. Chairman, from Dr. Gronvall, VA Chief Medical Director, dated September 27, 1988, which announced the VA's intention to cancel the SCI unit at Gainesville, makes no mention of MEDIPP data as the basis for the VA's decision. Rather, the VA cites certain vague "efficiencies" as the rational to ignore the need for SCI care that was clearly documented in the Department of Medicine and Surgery's own SCI expansion plan in 1985.

PVA strongly believes both SCI projects in Florida, Gainesville and Tampa, should proceed on schedule and as originally designed. The Tampa project itself is already way behind schedule. The need for both projects is very clear based on the attached maps showing the distribution of SCI veterans in the United States.

PVA would like to challenge the VA's assumptions on this latest change in Florida SCI construction with the following points.

- Florida has one of the highest concentration of veterans with spinal cord injuries or disease in the nation; a veteran population that is growing rapidly.

- Access to care for a person with a spinal cord injury is equally as important as the quality of service provided. The Gainesville catchment area serves SCI veterans in the entire northern tip of Florida, the Panhandle and counties in South Georgia and Alabama.

- Tampa, even with increased bed levels, would not be readily accessible for the majority of these veterans or their families.

On May 6, 1988, the Department of Medicine and Surgery released the "Draft Criteria and Standards for the Spinal Cord Injury Program." This document outlines procedures and guidelines for the entire SCI treatment program. The draft has been cleared through DM&S and is now awaiting the signature of the Chief Medical Director. The decision to eliminate the Gainesville SCI unit and shift 20 of its 30 planned beds to increase the Tampa project from 80 beds to 100 beds countermands these SCI treatment criteria and standards in at least two major ways. The guidelines are very specific in establishing siting criteria with special regard to access and distance traveled for veterans. More importantly, the guidelines directly recommend that SCI units be no larger than 60 beds for maximum efficiency and quality of patient care. The proposed expansion at Tampa to 100 beds far exceeds this VA recommended limit. We ask the Subcommittee to review this situation. We ask you to restore funding for the Gainesville project. It must proceed on schedule as originally planned.

Facility Development Plans

In 1985, the VA released a study conducted by Booz Allen Hamilton/RTKL which outlined deficiencies in VA construction planning and recommended major changes in planning organization and procedures. We concur with those recommendations. In January, 1987, almost two years after the BAH/RTKL Study, the VA initiated a pilot program at four VA medical centers to test an ambitious data collection system designed to inventory construction needs and assess the physical condition of each station. The Facility Development Planning Program (FDP), as it is called, is ultimately designed to repeat this same process at all 172 VA medical centers. Ideally, once this is done, the VA will then have a "menu" from which to choose to allocate construction dollars based on gradations of need and facility condition.

PVA fully concurs that a Facility Development Planning Process is sorely needed. In the absence of such a program, each year 172 individual medical centers are required to submit a locally-prepared list of construction projects. Under this procedure, projects are poorly defined, uncoordinated, and construction costs are consistently underestimated.

We do not believe that the current FDP process, as demonstrated by the four pilot projects, will correct this situation. The FDP process is cumbersome and expensive. Approximately $2 million has already been expended to hire private architectural firms to produce the pilot FDPs at the four medical centers.
To date, the Congress has appropriated $30 million for the VA to proceed with the FDP process. An additional $10 million is proposed in the Reagan Administration's FY 1990 VA budget for a total of, presumably, $40 million to let contracts to survey all 172 medical centers.

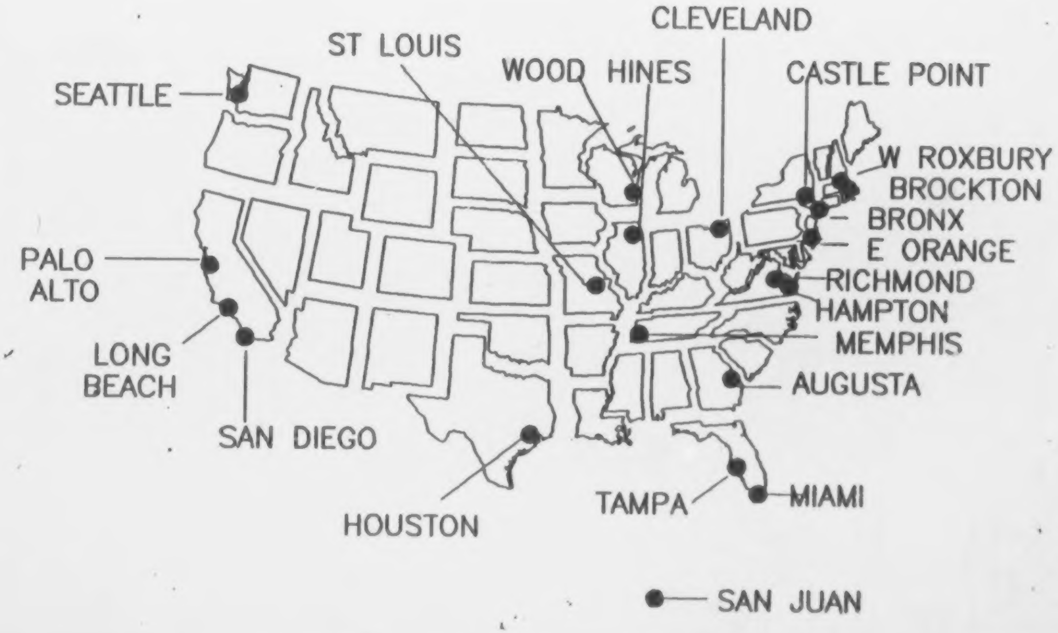
Based on our review of the cost of the pilots and the bids now coming in to complete FDPs at the first 40 VAMCs, the total cost of this project will eventually be far greater than the VA has estimated, the total price could escalate from the low VA estimate of $40 million to $100 million.

The exorbitant cost of this program is driven by the enormous amount of unnecessary statistical data contained in an FDP. The pilot project at the Marion, Indiana VAMC, for example, is 1,900 pages long. The "style manual" designed to describe how to conduct an FDP at each medical center is 700 pages long. This level of statistical detail, in our opinion, is basically irrelevant to the type of facility development process the VA really needs. It cannot possibly be updated to respond to constant changes in demographic forecasts, actuarial statistics, veteran eligibility requirements, building codes and standards, construction costs, MEDIPP changes and priorities. These documents will therefore have negligible utility. Since basic linkages to a national planning database were not initially established, it will be difficult and expensive, if not impossible, to later adjust the FDP data to reflect these changing national statistics. From this standpoint, the VA will be no better off in its planning process than it is right now. But the taxpayer will have paid as considerable price.

Within the next month, the VA Office of Facilities is scheduled to sign contracts for the first FDP's at 40 VA medical centers, embarking on a program that will cost millions of dollars and thousands of man-hours. In our view, a proper facility-development program is necessary and important. But this approach is seriously flawed. The proposed process relies too heavily on mammoth amounts of information generated from the bottom of the VA system to attempt to allow those at the top to make supposedly clear and coordinated decisions based on constantly changing needs and aging facilities. We ask this Subcommittee to take a careful look at the FDP program before the first contracts are let to be certain this is a prudent and cost-effective process to follow.

Mr. Chairman, this concludes our testimony. I will be happy to answer any questions you might have.

VETERANS ADMINISTRATION
SPINAL CORD INJURY CENTERS
1989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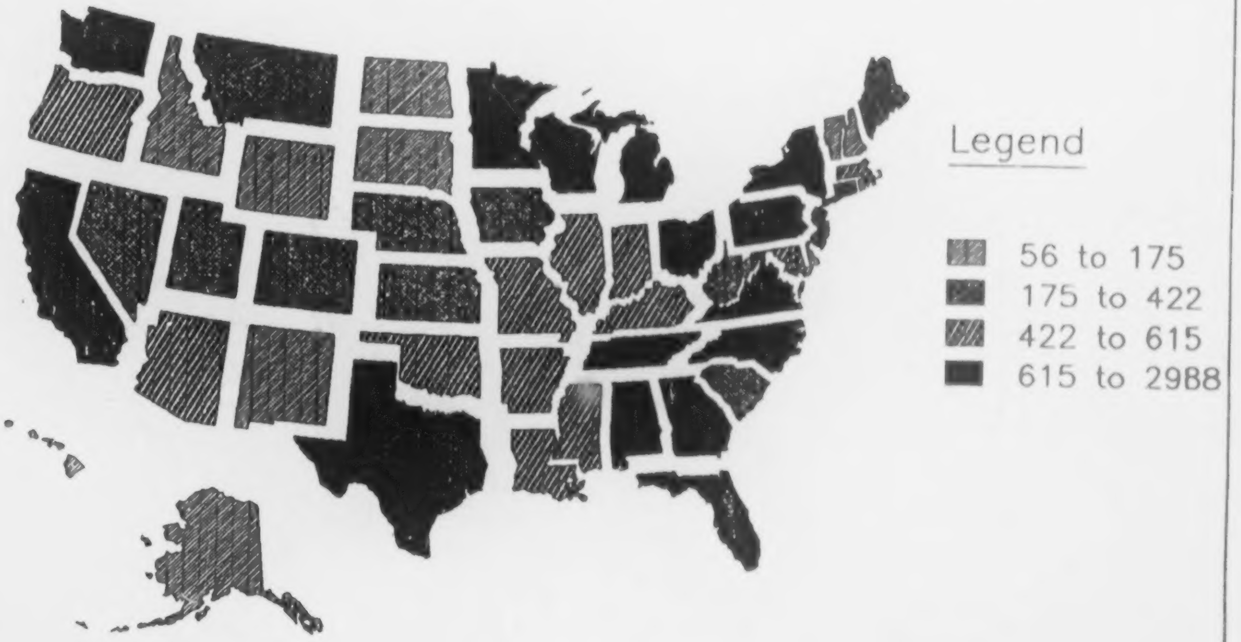
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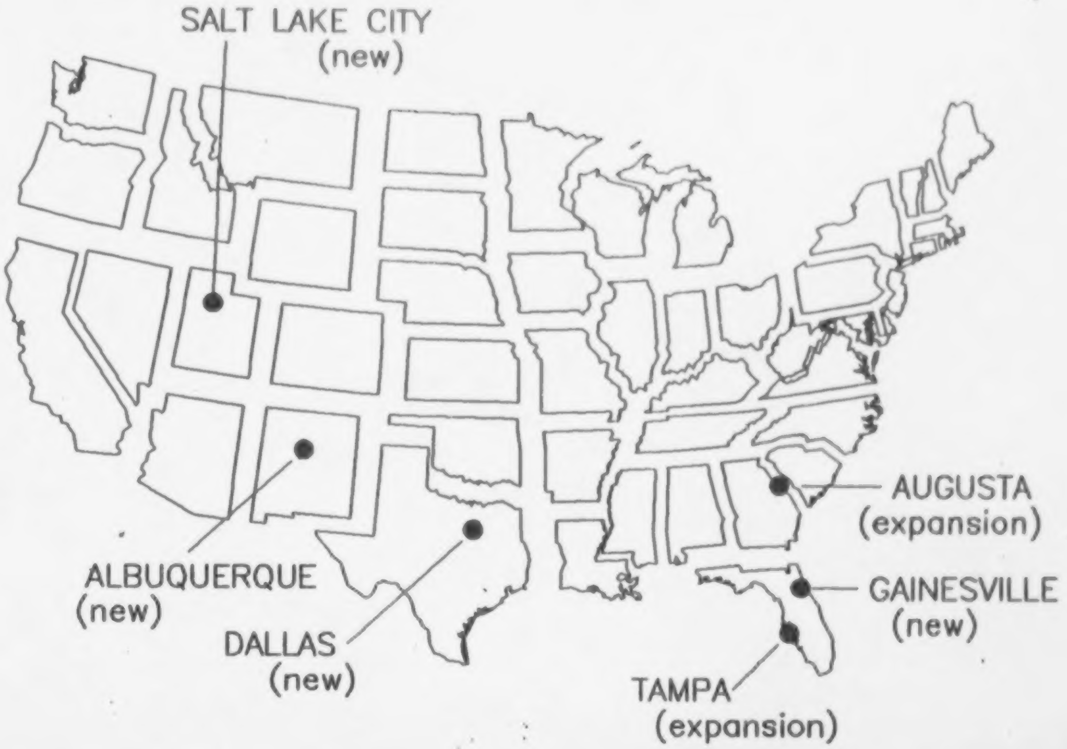
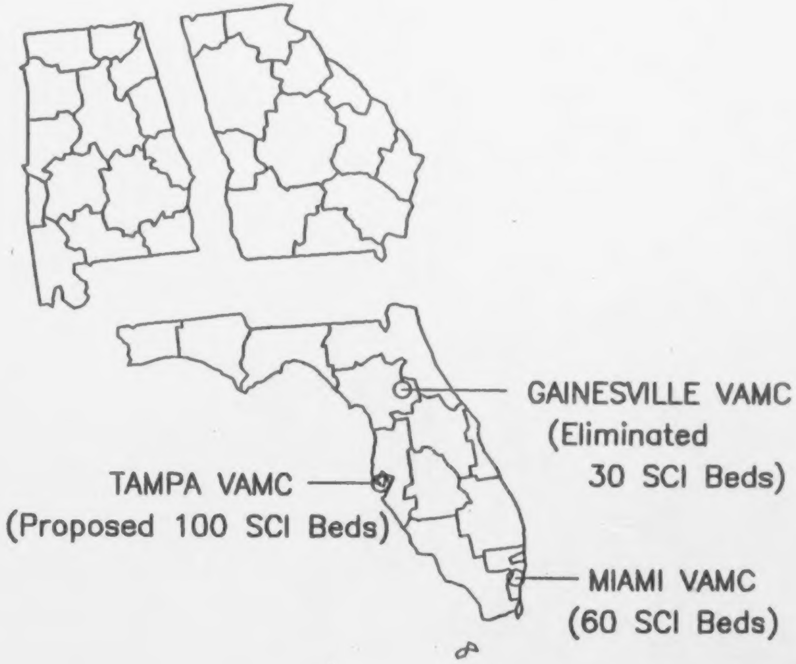
PROPOSED SPINAL CORD INJURY CENTERS AS OF FY 88


SALT LAKE CITY
(new)
ALBUQUERQUE
(new)
DALLAS
(new)
AUGUSTA
(expansion)
GAINESVILLE
(new)
TAMPA
(expansion)

1985 VA CONSTRUCTION PLAN
AMENDED FALL 1988
FLORIDA


GAINESVILLE VAMC
(Eliminated
30 SCI Beds)
TAMPA VAMC
(Proposed 100 SCI Beds)
MIAMI VAMC
(60 SCI Beds)

VETERANS ADMINISTRATION
Department of Medicine and Surgery
Washington, D.C. 20420

SEP 27 1988

10BA3

Honorable G. V. "Sonny" Montgomery
Chairman
Committee on Veterans' Affairs
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

I am writing to advise you of a recent change concerning the placement of Spinal Cord Injury (SCI) beds in Florida and to clarify related and planned construction projects at both Tampa and Gainesville VA Medical Centers.

The need for this clarification was brought to my attention after review of the House Congressional Record of May 26, 1988, under the heading of Function 700. More specifically, the language addresses support of the "psychiatric facility and Spinal Cord Injury Center in Gainesville, Florida."

Although it is correct that the Department of Medicine and Surgery had, at one point, planned for a SCI capability at Gainesville, this project was not a part of the psychiatric addition, but was a separate project included with planned expansion of nursing home care beds at the Gainesville VA Medical Center. Both the psychiatric addition and the nursing home projects are needed at the Gainesville facility, however, we have determined expansion of the Tampa SCI capability to be more appropriate than establishing a new SCI capability at Gainesville.

We have always projected an increased need for SCI beds to serve Florida's growing veteran population and since 1978 had planned to meet this need via the expansion of the unit at VAMC Tampa from 42 to 100 beds. These plans were altered in 1985 to reduce the Tampa bed allocation to 80 and create a separate 30 bed unit at Gainesville. The change appeared to offer the advantage of having the beds more geographically dispersed.

Since 1985, we have re-examined this plan and determined that returning to our original planned bed level for Tampa would be more cost effective and would provide the service in an area where the largest population of Spinal Cord Injured veterans currently resides. This demand is illustrated by the action the Tampa VAMC has had to take since 1985 by converting other

2.

Honorable G. V. "Sonny" Montgomery

hospital beds to bring their SCI operating beds to a level of 70. This action was necessary, as an interim measure, to keep pace with the growing demand for SCI care. The above, coupled with Tampa's role as one of the VA's designated Comprehensive Rehabilitation Centers and the many economies of scale to be derived from having one larger unit, have influenced our final decision.

Again, it should be noted that this action does not alter the need to construct the psychiatric addition at VAMC Gainesville. Our planning efforts will continue in this regard to meet the long term psychiatric needs of Florida veterans.

I sincerely appreciate your concern for VA Medical Programs and trust you will understand that this change in our planning will result in better access for veterans and greater efficiency in meeting the very special health care needs of spinal cord injured veterans.

Sincerely,

CHIEF MEDICAL DIRECTOR

JOHN A. GRONVALL, M.D.
Chief Medical Director

Executive Communications (101B)
SEP 27 1988
Signed and Dispatched

cc: Director, VAMC Gainesville, FL
Director, VAMC Tampa, FL

CONSTRUCTION PROGRAM

OVERVIEW

Two appropriations fund the bulk of the VA's construction activities: Major construction provides funds for projects costing more than $2 million; minor construction pays for smaller projects and also for the staff necessary to the planning and supervision of construction activities. In addition, a small third appropriation currently supports the Parking Garage Revolving Fund. Most funds in the construction appropriations are dedicated to health care projects.

THE CHALLENGE

Needs should form the basis for the determination of funding required for construction. Construction needs should be formulated based upon a formally institutionalized process that is designed to provide a rational analysis of construction requirements derived from a nationwide assessment of such requirements. However, the VA has failed to propose either a formal and institutionalized analytical process for the determination of nationwide priorities, or a formal inventory of needs assessments made at the treatment facility level. A rational process designed to project construction requirements in priority would require a knowledge of:

o Maintenance and repair needs of existing structures, systems (electrical, heating, plumbing, etc.), and equipment used by the individual medical center;

o Shortfalls in existing space, systems, and equipment needed for the current activities of the individual medical centers; and

o Shortfalls in the space, systems, and equipment that will be required by future medical center operations, as these future operations are envisaged in approved MEDIPP plans and designed to meet the changing nature and location of the current veteran population. (Also see discussion of MEDIPP on page 83).

The Facility Development Planning (FDP) Program, initiated in FY 1987, is the method selected by the agency to identify current and projected facility needs of individual medical centers. However, our independent assessment of the FDP Pilot Program indicates that these goals have not been achieved and the process has proven excessive in both cost and time. The agency's original estimate for full implementation of the FDP program was $40 million, an average cost of $250,000 for each medical center with a six-month time schedule. Although the agency has withheld detailed information on the pilot program, our investigations indicate that costs for at least two of the projects exceeded 100 percent of original estimates. In addition, all four pilot projects have been under development for more than a year. In fact, as of January 1, 1989, none of the pilot projects has yet been totally completed. This evidence suggests that initial direct costs to implement the FDP Program systemwide could approach $80-$100 million, not including the cost of VA personnel and support.

We recommend that the FDP Program be delayed until a more efficient and cost-effective process has been developed and that a greatly simplified system to provide basic facility data be quickly developed, independent of a facility master plan.. This system would provide a systemwide profile of VA medical center needs for resource allocation and signficantly reduce the cost and time required to develop individual FDPs, and immediate action is necessary to prevent further irreversable expenditures on this program. Further, we hold that the MEDIPP process remains essential to any national planning effort in that it provides a concept of construction funding priorities as envisioned by the several Medical Districts. We would therefore urge that the current MEDIPP process continue to be funded.

When a revised FDP process is fully functional, with procedures implemented to ensure useful and current data, the VA will then possess an inventory of current facility needs. Such an inventory also will support a more rational process within the several medical districts in the preparation of their annual MEDIPP projections. It remains, however, that neither process, alone or in combination, will be sufficient to permit the VA to establish a set of nationwide funding priorities for construction that will meet the current and future needs of the veteran population. The data provided by the FDP and the MEDIPP will form the base for planning, but it will be necessary to create a formal institutional process that will permit the VA to formulate a nationwide construction strategy. This will help justify VA funding objectives to the Administration and the Congress and will permit the rational allocation of such construction funds.

The absence of a sound basis for the establishment of construction priorities at the national level is but one of the major deficiencies in the VA construction process that have been identified by studies the VA itself has commissioned. Other major deficiencies include:

o Excessive time required for construction projects, being typically 10 years from conception to completion for major construction.

o Costs that are sometimes excessive.

o The inability of the VA to deal systematically with problems that arise in the construction process.

Appendix D: "Problems in the VA Construction Process," describes the major findings of these studies and provides more detail concerning these challenges.

THE STRATEGY

Our most urgent construction program concern, then, is for the VA to develop a facility planning and design process that works well, and specifically one that:

o Completes projects more rapidly; five years from the conception to completion of major construction projects is held to be an appropriate goal.

o Chooses projects based upon a rational assessment of requirements nationwide and on a sound system for setting priorities among those requirements.

o Provides projects that meet medical centers' needs well, whether current or future.

o Is economical.

o Catches problems quickly, before they become severe, through an effective system of standards and indicators for monitoring ongoing performance along such dimensions as quality, timeliness, and cost.

An immediate task for the agency in meeting these goals is to complete the development of a sound Facility Development Planning process. Successful completion of the pilot test program for the FDP, involving four VA medical centers, remains a prerequisite to the implementation of this process system-wide. Once a proper FDP process has been established, the foundations necessary to the development of a needs-based construction budget will be in place.

Neither we nor the VA know what the true construction needs of the VA are. However, projected against a rationally devised assessment of nationwide requirements, with priorities established to meet changing conditions, technologies, and demographics, we can acknowledge an immense shortfall in construction maintenance, upgrade, and replacement based upon our own data sources. Accordingly, we have recommended a total construction appropriation for FY 1990 in the amount of approximately $922 million. This amount incorporates all of the major construction needs projected for FY 1990 by the VA in its current Five-Year Medical Facility Development Plan. Within our total projections, we have also allocated a significantly increased sum for minor construction in recognition of what we hold to be a wholly unacceptable and rapidly accelerating deterioration of the current physical plant, a process now well underway. We hold that our projections for FY 1990 are hardly excessive, noting for example that the VA is now contracting for only two hospital replacements, or top-to-bottom renovations, annually. At this rate, the VA is operating on an 86-year replacement cycle for its 172 hospitals. We believe such a lengthy apparent replacement cycle is wholly unacceptable.

The FY 1990 IB also reflects the reestablishment of a reasonable strategy for locating cemeteries in the National Cemetery System. At OMB's insistence, the VA has for years maintained that the system need have no more than one National Cemetery, with available burial space, in each of the ten federal regions. In too many cases, this means extremely long travel distances for the widows and children of veterans honored by burial in a National Cemetery. Realistically, it deprives many veterans of the option of burial in a National Cemetery.

The VSO authors of this budget are unanimous in agreeing that a true National Cemetery System that actually offers veterans what it has appeared to promise must meet two criteria:

o The National Cemetery System must provide at minimum a National Cemetery with available grave space in every state. Eight states do not now have open National Cemeteries.

o There must be a National Cemetery with available grave space within reasonable distance of each of the nation's major veteran population centers.

The FY 1990 IB has been designed to assist the National Cemetery System to begin to meet these criteria.

SPECIFIC RECOMMENDATIONS

The specific recommendations for construction programs, as in other program areas, in the FY 1990 IB are based upon our concept of the strategy necessary to meet the challenges in this program area.

MAJOR CONSTRUCTION

We recommend that $635 million be appropriated for major construction in FY 1990. Our source for funding needs projections for FY 1990 has been the VA's current Five-Year Medical Facility Development Plan. While we recognize that the specific projects to which these funds are dedicated may not meet the priorities that might be developed in an in-depth analysis of national requirements, we also recognize that to achieve less in FY 1990 would be catastrophic in view of the current replacement cycle, changing clinical requirements, and the age of current plants.

Within the $635 million total, we have continued our recommendation for the allocation of $40 million to the advance planning fund and the design fund, as shown at Table 15. It is intended that tnese funds permit projects to move more expeditiously through the planning and design stages of the construction process. As such, they are intended to deal with one of the major problems that has excessively delayed VA projects in the past. The $40 million recommended substantially exceeds the amount allocated to these purposes in the past. In funding them generously, the FY 1990 IB seeks to accelerate the construction process. More importantly, the FY 1990 IB seeks to ensure a large dollar volume of projects in the pipeline. Underfunding in this area chokes off projects by constricting the front-end planning and design stages. A strategy of strong support for planning and design will permit rapid

TABLE 15
CONSTRUCTION PROGRAMS
(dollars in thousands)

CONSTRUCTION CATEGORY	1987 APPROP.	1989 APPROP.	1990 RECOMM. APPROP.
MAJOR CONSTRUCTION			
Medical			558,920
Advance Planning Fund And Design Fund			40,000
Nursing Homes			30,000
Cemeteries			6,000
TOTAL MAJOR	403,000	363,040	634,920
MINOR CONSTRUCTION			
Medical			200,000
General			[160000]
Conversions			[40000]
Regional Offices			5,000
National Cemetery Program			10,000
Staff Offices and Admin.			60,000
TOTAL MINOR	116,000	111,600	275,000
PARKING GARAGE REVOLVING FUND	3,900	26,000	12,000
TOTAL CONSTRUCTION APPROPRIATION	522,900	500,640	921,920

expansion of the overall volume of necessary major construction projects once the VA's process for priority setting has been rationalized.

The FY 1990 IB has designated $30 million for the construction of new VA nursing homes. This amount will permit the funding of 4 new nursing homes of 120 beds each. Aging of the veteran population will require this rate of addition of new VA nursing homes throughout the 1990s. We hold that this rate of nursing home construction will exist independently of VA compliance with our recommendation, which the FY 1990 IB also funds, to convert 1000 existing hospital beds to nursing home use annually through the 1990s, with a one-time conversion of approximately 2000 such beds to this purpose in FY 1990.

Finally, our recommendations for the major construction appropriation include $6 million for the acquisition of land for new National Cemeteries in states that currently have none. The VSOs recommend the addition of two new national cemeteries annually until the National Cemetery System has met the VSO goals already articulated.

The remaining approximately $559 million of the major construction appropriation should be devoted to those other medical construction requirements, all of which we hold valid, which have been identified for FY 1990 by the current Five-Year Medical Facility Development Program.

MINOR CONSTRUCTION

The FY 90 IB recommends an appropriation of $275 million for FY 1990. The minor construction fund pay for smaller projects devoted mostly to keeping VA facilities in repair and, within dollar constraints, up-to-date. As shown at Table 15 the IB recommendation for FY 1990 significantly exceeds the appropriation for FY 1989. As such, it represents the urgent and growing concern of the VSOs for the updating and repair of existing VA facilities. The largest number of VA facilities date from the 1950s. They are at an age now where the need for updating and repair is high and growing. Earlier appropriations have fallen far short of meeting this need.

Most of the projected minor construction funds, the sum of $200 million, has been identified for medical construction. Of this amount, the FY 1990 IB recommends that $40 million be set aside for the conversion of existing medical center space to nursing home use, to be made available for this purpose only. It is estimated that $40 million should be sufficient to permit the conversion of 2,000 bed spaces to this purpose in this fiscal year, and reflects the concern of the VSOs that the 1,000 bed conversion recommended in the FY 1989 IB was not accomplished. The VSO analysis of nursing home needs and how to meet them indicates the need to convert approximately 1,000 VA hospital beds to nursing home use each year for the next several years. To date , VA medical centers have resisted the actual undertaking of such conversions, to including those that have been called for in the DM&S' own planning process. A set-aside of $20 million annually for conversions, $40 million in FY 1990, would put an end to the claim that a lack of construction funds prevents such conversions. The VSOs hold that primary responsibility for the provision of adequate nursing home care to the nation's aging veteran population rests with the federal government.

Modest amounts of the minor construction appropriation support construction projects in the VA's Regional Offices and in existing National Cemeteries. Based on recent year's spending patterns, the FY 1990 IB projects $5 million and $10 million, respectively, as appropriate to these purposes. Finally, the IB projects $60 million in minor construction funds to be spent for the VA staff that oversees the construction process. This consists primarily of the Office of Facilities. This projection should permit the continuation of staffing at least at current levels, and demonstrates again the concern of the VSOs that the VA take steps to develop a formal institutional process that will permit assessment of construction requirements in terms of a nationwide strategy defining construction priorities.

PARKING GARAGE REVOLVING FUND

The FY 1990 IB recommends a $12 million allocation to this fund. The Parking Garage Revolving Fund is a recently established appropriation. When the fund is fully established, revenues from the parking garages, which it has financed, will pay for needed new parking facility projects; limited, new appropriations to the fund will be required. Currently, however, the fund remains in a start-up mode, with the few projects it has undertaken yet to produce revenues. In this regard, reasonable access to medical treatment is an essential element of the treatment process.

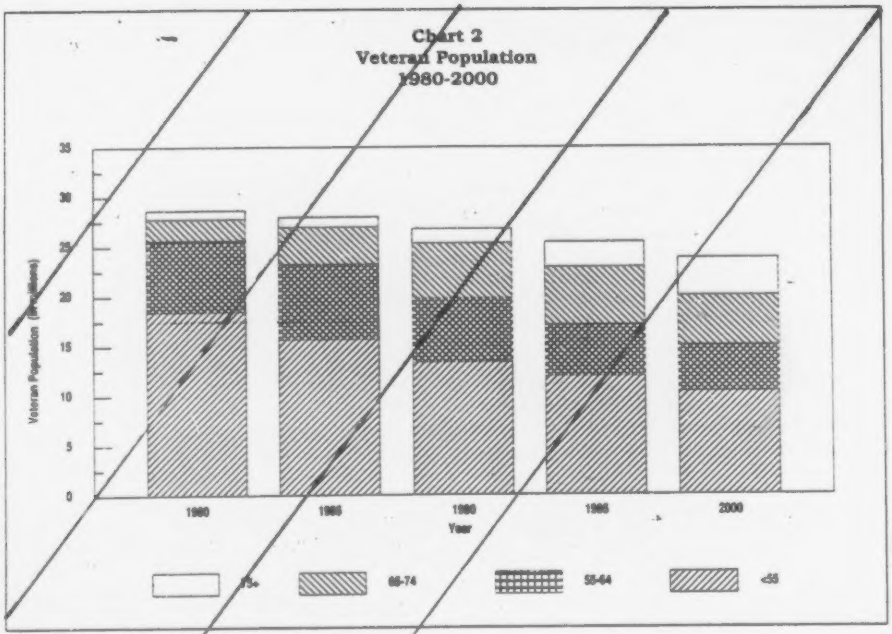


Chart 2
Veteran Population
1980-2000

beyond 65--they require progressively more health care, and their need for long-term care grows even more rapidly than their need for acute care. A few statistics on veterans' actual use of VA care underscore the point. As seen in Chart 3 on page 69, veterans aged 55-64 are the highest users of VA inpatient care among veterans under 65, using inpatient care at twice the rate of veterans under 25. However, veterans aged 65-74 still use VA hospital care 32 percent more, and those over 75 use this type of care 75 percent more than the 55-64 age group. Although this increase in use of VA inpatient hospital care is dramatic, it is small compared to the statistics for nursing home care. Chart 4 on page 69 shows nursing home use by men 85 and older is almost 30 times the use by men 55 to 64.

Meeting this rapidly growing and changing need of the aging veteran population is a very significant driving force behind our policy for the medical care appropriation.

VA PLANNING FOR THE HEALTH CARE SYSTEM

The VA health care planning system MEDIPP, was conceived and implemented as a mechanism to establish strategic and operational direction for the medical care system. Although the planning resources and processes have been in place for several years, the planning leadership has lacked the understanding, courage, and conviction necessary to force the process to respond responsibly. In the opinion of the VSOs, each change in the planning system has weakened it and with responsibility now residing in the Regions--the line offices that direct system performance--the program can produce but questionable benefit. This is exemplified by MEDIPP generally being perceived by the medical center directors and the medical districts as a mechanism through which program enhancement and increased resources can be accomplished rather than a mechanism through which system change can be managed. If the planning program had been functioning as originally envisioned, MEDIPP would have been responding constructively to the continuing budget shortfalls and the system would not have found itself in a crisis situation in May 1989. The likely conclusion about MEDIPP now is predictable: The VA will pronounce that the system does not produce the desired result and it should therefore be abolished and planning left to the line officials. The VSOs strongly disagree with this position and suggest that DM&S step back and carefully assess MEDIPP and make the difficult decisions that will allow it to function in a manner supportive of the VA mission and top management decision making. Medical districts where MEDIPP functions effectively should be used as models for the entire DM&S. Suggestions for some general revisions of the VA health care planning program are presented on page 83.

VSO STRATEGY

REALLOCATE BENEFITS SAVINGS TO MEDICAL CARE

In part, the funds needed to accommodate the growing health care needs of the aging veteran population and address current quality and access problems could become partially available through the decreasing requirements of the aging of the veteran population on veterans' benefits programs. In much of the benefits area, unlike the medical area, the numbers of veterans receiving VA benefits will decline in future years. (Some specifics are pointed out in preceding sections on veterans' benefits programs.) As a result, in future years, the cost of the benefits will increase less rapidly than inflation. Any savings from benefits programs should be regarded as funds available to meet health care needs.

EXPAND NON-INSTITUTIONAL CARE PROGRAMS

Beyond this, our strategy to deal with unmet and growing needs in light of budget constraints continues to focus on rapid expansion of non-institutional health care programs. This focus holds in both acute and long-term settings. These non-institutional care programs not only cost less than institutional care but also provide veterans more independence and more opportunity for living with their families and in their communities.

The historical roots of the VA system, like its affiliated academic health care centers, are in institutional care--hospital inpatient care on the acute care side and nursing home care on the long-term care side. Like the private medical sector, the VA system has been moving to more use of non-institutional care--that is, to expanding both outpatient acute care and a variety of non-institutional long-term care modalities--and the results this last year have been gratifying in some respects. The shift to non-institutional care modalities must be continued; it is an important direction for the future.

MORE CLEARLY DEFINE VETERAN NEED

Another component of our strategy for addressing with unmet need is to undertake a series of data-gathering activities to identify more accurately the extent and character of the quality and access issues confronting veterans seeking and receiving health care. The House and Senate Veterans Affairs Committees have initiated action in this area by requesting the Government Accounting Office to "conduct a study to estimate the current and potential demand for VA outpatient care of veterans who have entitlement to VA hospital care." This must be supplemented with information to more accurately identify the unmet need of veterans for hospital, nursing home, and domiciliary care.

SPECIFIC RECOMMENDATIONS

Specific recommendations to implement this strategy follow. These recommendations are discussed in two general categories. First is the imperative to maintain current services--i.e., to continue to provide the same level of VA medical care services as was provided in FY 1988[2]. (Corrected for the deficiencies noted below). This followed is by specific program recommendations. Table 8 identifies these recommended programs and funding levels.

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[2] The assumption here is that the independent recommendations for a FY 1989 supplemental appropriation to meet the current services shortfall is acted upon its entirety.

~~*Partially Fund Replacement Equipment Backlog*~~

~~Recent communications with the VA provide evidence that the VA will have a backlog of object class 31 and 32 replacement equipment of close to $1 billion by the end of FY 1989. This figure has been very difficult to ascertain and it has taken repeated effort by the Independent Budget staff to collect information concerning the backlog. It is also clear that central information is not available on new additional equipment that is requested by the medical centers and is denied at levels above the medical center. The VSOs have included $200 million in the FY 1989 supplemental and a $200 million FY 1990 appropriation request for equipment. If this supplement of funding is not made available, the amount needs to be incorporated in the FY 1990 appropriation. In addition, the VSOs feel that an additional $100 million should be funded in FY 1990 to provide the first installment in a multi-year appropriation that would reduce the backlog of needed medical equipment over the next 3-4 years.~~

~~*Pursue the Implementation and Evaluation of the Homeless Chronically Mentally Ill (HCMI) Veterans Program*~~

~~This program established by P.L. 100-6 and extended through FY 1988 by P.L. 100-71 and P.L. 100-322 is designed to help those who are least able to help themselves. The legislation authorized $15 million but Congress did not provide specific appropriations for the program in FY 1989. The supplemental funds requested under the current services discussion includes funds for the HCMI program. Therefore no funds are requested in this portion of the budget.~~

~~Since its inception it has had an intake of 10,524 veterans through March 1988 in 43 metropolitan areas. These veterans who were identified in shelters, soup kitchens, abandoned buildings and on the streets have extensive need for care since 80 percent of those assessed at intake presented either a general psychiatric or substance abuse problem. Twenty-nine percent of those veterans had medical examinations which indicated that 88 percent of them had a diagnosed illness. Of importance is the judgment that 60 percent of the medical care need could be provided on an outpatient basis.~~

~~This unmet need is a major challenge to be met and is further discussed on page 88 under Unmet Needs Survey For more detail see Appendix C. the Veterans Administration report to the Congress on the Homeless Chronically Mentally Ill Veterans Program December 1988.~~

~~**Pharmaceutical Unit Dose Program**~~

~~A program was initiated around 1980 for installation of the "unit dose" system in all VA hospitals for dispensing of pharmaceuticals. Incremental funding since that time was discontinued in FY 1987. Fifty VAMCs are still waiting for the resources to acquire the unit dose capability for increased patient safety, cost economy and security from theft in the handling of inpatient medications.~~

~~Although we are not recommending additional funding for this purpose in this austere budget year, we are constrained to note for the record the cessation of this worthy program is yet another example of regression due to underfunding. A completion date for installation of unit dose capability in all remaining VA hospitals should be targeted for the not too distant future.~~

STRENGTHENING THE MEDICAL CARE PROGRAM

It is the recommendation of the VSOs that steps must be taken now to move the health care system forward in response to clearly changing health care needs of veterans and to the shifting modalities of care. The changes we recommend will address many of the problems that currently exist and anticipate future needs.

Revise the VA's Health Care System Planning

The Department of Medicine and Surgery is facing a funding crisis in FY 1989 and outyears. After examining events related to this crisis, the authors of this Independent Budget conclude that the MEDIPP process, the VA health care system's planning program, had not succeeded in commu-

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~~[*] The data on outpatient visits include same-day dialysis treatment, which the VA had previously counted as inpatient episodes.~~

nicating program and funding problems and providing alternatives for their solution. This is supported by the fact that the Chief Medical Director convened a task force to consider options for dealing with the "funding shortfall." The "shortfall" did not suddenly happen in the spring of 1988: it was the culmination of events that took place over a number of years, due partially to expansion of program activities outside the MEDIPP process. However, even the Medical Districts have used the MEDIPP process to justify program expansion rather than assess the current situation and develop strategic and operating plans to address the fundamental issues. The Chief Medical Director (CMD) apparently has no faith in the current program, and, based on our knowledge, neither do the Regional Directors--the VA health care system's line field officials. We fear that the MEDIPP program will be abandoned by the Department: however, we also know that planning is essential to the management of the VA health care system in a time of stress and resource constraints. Based on this assessment, we recommend that MEDIPP be restructured, since without strong central direction the field will plan for an ever-increasing resource base and the Central Office will ignore the input, even the input designed to communicate problems and the alternatives to their solutions.

A more critical problem presents in the relationship between the Facility Development Plans (FDP) and MEDIPP. Since the FDP derives its future direction from MEDIPP workload and program projections, MEDIPP must be realistic and accurately reflect the direction of the health care system. MEDIPP must produce a valid and reliable product since billions of dollars in construction funds are dependent on the strategic and operating products of medical care system planning.

We recommend four steps in the planning process.

1. Strong central strategic and operations direction from the Chief Medical Director.

2. A directive to the Regional Directors to develop workable alternatives for achieving the strategic direction of the Chief Medical Director and operational direction defined through a carefully executed MEDIPP process.

3. A set of decisions on implementation feedback provided to the Regional Directors and District Directors by the central office.

4. A strong, valid, reliable link built to the Facility Development Plan.

Data bases and models to assess alternatives should be developed by district teams to support the entire planning program. The program should be supported with the current district/regional staff and a core strategy group in the central office that has extensive experience in corporate hospital and hospital system planning. The name of the game is health care service to veterans: efficient, cost-effective, high quality care. The planning, resource allocation, and quality of care programs must mesh in a symbiotic fashion to meet the challenges of the 1990s. This symbiosis is sadly lacking in the VA central management program.

The VSOs anticipated the crisis, erosion of the quality, and unfunded workload. It seems to these authors that the Department of Medicine and Surgery and the MEDIPP process must also have anticipated these same conditions and should have posed a solution long before a crisis emerged. Much more attention must be given to strategic direction and planning for the future.

Human Resources Development

Staffing Shortages. Staff shortages of health professionals in the VA have been a recurring problem for some time. It has now reached critical proportions with scarcity of allied health personnel second only to the shortage of nurses.

Hospital labor shortage is in fact one of the most pressing issues facing the nation's health care system. It is not confined to the nursing profession nor to particular locales. The whole field of rehabilitation, for example, is faced with a short supply of personnel, including physical therapists, occupational therapists, speech and hearing therapists, and laboratory technicians. The intensity of private sector competition for recruitment of these scarce professionals has the VA at a distinct disadvantage.

Several thousand VA hospital beds are allegedly closed for want of necessary staff. Taking note of this detriment, the FY 89 Independent Budget urged the implementation of a human resources plan for all employees to create the kind of environment that recognizes their professional contributions, assures competitive pay scales, provides for professional growth, and accommodates their

STATEMENT OF RICHARD S. CHRISTIAN, DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
FEBRUARY 1, 1989

Mr. Chairman and Members of the Subcommittee:

The American Legion is pleased to appear before the Subcommittee today to present its views on the present and future status of the Veterans Administration's Medical Construction Budget. Before addressing the issue under consideration today, we would like to state for the record that The American Legion was greatly pleased at the enactment of the "Department of Veterans Affairs Act" in October 1988. This satisfied a long-sought goal we had been pursuing for over two decades. However, since the provision redesignating the Veterans Administration as the Department of Veterans Affairs is not effective until March 15, 1989 we shall address the agency in this statement under its current designation. May we say at the outset that The American Legion is an ardent supporter of a medical construction program that is adequate to the needs of all veterans. Our position has been reinforced as a result of information obtained through site visits conducted by American Legion Field Representatives at VA medical centers and clinics. The site reports include detailed descriptions of the needs and problems of VA medical center personnel who many times must practice modern medicine under less than optimum conditions, in part due to outdated and inadequate facilities.

The VA medical care system, as we know it today, was developed in the late 1940's and early 1950's to meet the health care needs of sick and disabled WW II veterans. It was expanded as the nation experienced two major conflicts, in Korea and Vietnam, which have further burdened the system. While the original mission remains, the VA medical system must also evolve to meet the particular health care needs of an aging veteran population. Available 1988 figures indicate there are 9,884,712 veterans 65 years of age and older, of which approximately 1.2 million are over the age of 75. There are an additional 5,890,198 veterans between the ages of 50 and 59. In addition, the VA medical care system has been designated by the Congress as a contingency resource for the Armed Forces in the event of a future conflict or natural disaster.

The practice of modern medicine has changed both in its substance and methods of provision. Modern technological and medical developments, totally unknown when many of the VA hospitals were constructed have evolved. The recognition and treatment of new diseases have also produced new demands. In order for the Department of Medicine and Surgery to keep pace with such developments and to ensure quality medical care is being provided, it would be reasonable to conclude that, in view of the age of many VA hospitals, after a 25-30 year period or more major renovation or replacement would be needed.

While there have been replacement, modernization and renovation of some hospitals, the efforts have not been adequate to meet current needs, in our opinion. The American Legion's site visit reports reflect complaints of the deterioration of some facilities and unmet needs of veteran patients. Our survey of physical plants reflect operating rooms requiring the presence of new and more sophisticated equipment and twice the available space. The provision of acute medical services has changed from a concept of total in-house care to an added emphasis on outpatient ambulatory care. In addition, the increasing aging veteran population is creating a need for an expansion of services related to geriatric care. Examples of the need for expanded geriatric care are nursing homes, domiciliaries, and other services associated with aging veterans. These are but a few examples of the need for a continuing, well planned, and well funded construction program.

The FY 1990 budget proposal of $487.6 million reflects an overall decrease of approximately $13 million in construction funding from the current fiscal year.

The FY 1990 budget proposal addresses needed facility replacement and modernization by assigning $183 million for that purpose. This figure represents a $41 million increase from the preceding year. Funding for other major improvements which was not identified was increased by $26.9 million. The American Legion views these funding increases as necessary and prudent.

We note, however, reductions in certain construction categories from the preceding year. The FY 1990 budget reflects a loss of $41.5 million in Nursing Home Care, $32 million in Domiciliaries, $18.9 million in the Parking Garage Revolving Fund, and $58 million in Environmental Improvements in Patient and Nursing Home Care buildings.

The major construction program is proposed to receive $365.8 million in new budget authority, which represents a decrease of $2 million from the FY 1989 authorization. Additionally, the minor construction program is proposed to receive $114.7 million, representing approximately a $9 million reduction from the previous year's level. The bottom line is that the overall FY 1990 budget proposes funding that is lower than in each of the preceding three fiscal years. We do not believe the physical plant of the Veterans Administration can ever be considered sufficiently funded when annual appropriations for renovation and replacement are declining. The physical resources of the VA medical care system are numerous, diverse and, on average, old. More needs go unmet from year to year than are corrected. We are optimistic that new needs identification planning procedures developed within the VA Office of Facilities will comprehensively identify the VA's capital facility requirements. Once properly identified, we trust that funding will be forthcoming in order to develop appropriate action plans.

The FY 1990 major construction proposal recommends obligating $53.7 million for the modernization of the Newington, CT medical center; continued funding in the amount of $17.2 million for major environmental improvements to patient and nursing home care buildings at the North Chicago, IL medical center; and the obligation of $112 million for the construction of a new medical center in West Palm Beach, FL. We are supportive of these proposals and can attest to their need.

We also support the initial proposal to provide $9.3 million in design funds for a Joint VA/Air Force medical center at the Nellis Air Force Base in Las Vegas, NV, and we applaud the several proposals for necessary building renovations, structural seismic corrections, asbestos abatement, fire and safety improvements, and clinical improvements.

As we have commented on previous occasions before this Subcommittee, construction priorities of the VA should closely reflect the grassroots planning proposals emanating from the Medical District Initiated Program Planning (MEDIPP) process. We believe the medical construction budget should encompass all of the related health care requirements on a prioritized basis.

While the 1990 budget proposal does address some serious problems, it does so at the expense of providing for proper care of a rapidly aging veteran population which will need longer and more intensive hospital care, nursing home care, and expanded domiciliary space.

There is no doubt that VA constructed nursing home care units are more costly due to federal regulations. However, it is also true that the patients found in the VA nursing home units often are severely disabled, require more intensive care and more sophisticated facilities than can be found in many private sector nursing homes. There is a serious need for the VA to continue planning, funding and development of nursing home units where appropriate.

Upon review of the status of the Outpatient Care Satellite Clinics Program, the 1990 budget indicates that five clinics will be activated. Nine (9) awards are intended for FY 1990. Of concern, however, to The American Legion is the fact that funding shortfalls may delay the activation of the five clinics. We are aware that activation funds for this fiscal year were diverted to personnel accounts. At a time when more emphasis is being placed on ambulatory care, as a result of new medical treatment procedures, and an emphasis on cost containment, this program must be appropriately funded to allow ongoing and accessible quality care for our nation's veterans. We will continue to monitor this situation and will be happy to apprise the Subcommittee of our findings.

The Veterans Administration has nineteen (19) spinal cord units in operation. Four more units are scheduled as follows: Albuquerque, NM in November 1990; San Antonio, Texas in March 1991; Salt Lake City, UT in March 1992 and Dallas, TX in April 1998. The unit in San Diego opened in September 1988 but currently is providing treatment only on an outpatient basis due to an apparent lack of funds necessary to activate the unit.

Upon review of the location and occupancy rates we must question whether the units are being properly located to allow easy accessibility to veterans of limited mobility. The Department of Medicine and Surgery in apparent recognition of these facts has initiated a training program to allow them to place trained spinal cord injury personnel in outpatient care facilities to treat minor problems and refer serious conditions to one of the major centers.

Central to the development of effective needs identification, and planned implementation for meeting those needs, is the "Facility Development Planning Process." The American Legion generally supports the concept of the FDP in that it identifies both short and long-term needs of the VA. The program, if followed, allows for effective and timely budgeting of new construction as well as replacement and modernization of existing facilities. The program identifies needs and specific strategies necessary to accomplish these objectives. The program should provide a cost effective tool for the VA to meet its obligations and to further present budget requests which will reflect an objective basis for increased funding requirements.

A cornerstone of the FDP is the Capital Facilities study. With this system, the VA has clearly demonstrated the need for renovation or modernization of 52.3% of its medical center physical plants.

The FDP provides a methodical approach allowing for recognition of both short and long-term needs and viable solutions to these needs.

In conclusion Mr. Chairman, it is a goal of The American Legion ensure that top quality medical care is provided to all eligible veterans. To achieve this, Congressional support must be continued to maintain the capital plant of the VA medical system. Adequate funding must be authorized and appropriated to upgrade and replace existing facilities. Meeting the diverse and increasing needs of aging veterans in conjunction with its other obligations presents a serious challenge to the Department of Medicine and Surgery. The ability to meet these challenges continues to be severely constrained by budgetary shortfalls. You may be assured that The American Legion will continue to closely monitor ongoing renovation and replacement projects, and other construction, both major and minor. As is our present practice, we will continue to provide copies of our site visit reports to the Veterans Affairs Committees. These reports contain information on the progress of ongoing construction as well as construction needs that are identified at specific VA medical care facilities.

Once again, we thank the Subcommittee for the opportunity to present our views.

STATEMENT OF HON. MARVIN LEATH

February 1, 1989

Honorable G. V. (Sonny) Montgomery
Chairman, Committee on Veterans' Affairs
335 Cannon H.O.B.
Washington, D.C. 20515

Dear Mr. Chairman:

Since I am unable to attend the hearing this morning, I would greatly appreciate it if you could relay my concerns for two projects pending at the Olin E. Teague Veterans Center in Temple.

A replacement domiciliary is scheduled to be completed in April, yet information I have received indicates that there are no funds to furnish or staff the building once it is completed. I would like to ask if the $1.5 million needed for activation will be included in the construction budget, and if not, that it be included.

The second project calls for construction of a 300-bed building to house all of the center's acute medical and psychiatry beds. Building 162 was constructed in 1965 as a 240-bed psychiatric facility and currently houses 275 medical, intermediate, and rehabilitation beds. It is a one-story structure with narrow corridors and low ceilings, does not meet current VA space standards or federal handicapped accessibility standards and is not suitable for modern acute medical care.

The existing Psychiatry Buildings 17, 18, and 19 were constructed in 1942. They are two-story buildings of wood-frame construction currently housing 30 beds each on the first floors. Since the Life Safety Code does not permit health care occupancy in a structure of this construction type, a VA equivalency was obtained in 1978 to permit continued use of these buildings if the second floors were kept empty. Since the Joint Commission on Accreditation of Hospitals (JCAH) will not accept a VA equivalency and since a separate JCAH equivalency has not been issued, continued use of these buildings could jeopardize the Centers' accreditation.

The VA construction budget includes $14 million for miscellaneous design projects. I would like to ascertain if these funds include design work for the bed replacement project in Temple. The design funds were to be included in the 1989 budget, with construction funds to be included the following year. Unfortunately, the project was bumped back and I am interested in getting the project back on track.

Mr. Chairman, I thank you for any information you might obtain for me regarding these two projects.

Sincerely,

Marvin

MARVIN LEATH
Member of Congress

ML:dcd

Statement of the Hon. Bob McEwen
February 1, 1989
Hospitals and Health Care Subcommittee
Medical

Thank you, Mr. Chairman.

I would like to commend you and our Ranking Minority Member for your prompt action to reveiw the Veterans Administration's Proposed Medical Construction Budget.

This particular budget symbolizes the nature of our commitment to America's veterans. If the Congress approves legislation authorizing compensation benefits and health programs, but then the VA does not maintain the physical resources to deliver these services, how are we to insure this care for veterans.

If we are to continue to provide quality medical care and services, it is imperative that we perservere in this vital effort to update our VA hospitals and other medical facilities to address their needs.

Mr. Chairman, I am concerned over findings of the recent assessment of the physical status of VA medical facilities built before 1970.

Within the State of Ohio, the Chillicothe VA Hospital was rated poor.

The Cincinnati and Breckville VA Hospitals are rated fair.

The Ft. Thomas, Kentucky and the Wade Park medical facilities are rated failing.

Also, Mr. Chairman, during our oversight hearings on the VA health care system last September, we discovered that many hospital directors were using funds from equipment accounts to cover payroll rates for certain health care professionals.

Our VA facilities need to be updated, and we need to give these hospitals the resources to fulfill their responsibilites.

Mr. Chairman, we must not be short-sighted in our approach to remedy the current situation or else we will create unnecessary and even greater problems over the long-run for the VA system.

Thank you Mr. Chairman. I look forward to hearing the testimony of our witnesses this morning.

STATEMENT OF CONGRESSMAN CHARLES W. STENHOLM

FEBRUARY 1, 1989

DURING THE LAST CONGRESS THE ADMINISTRATOR APPROVED RETENTION OF THE SURGICAL UNIT AT THE BIG SPRINGS VAMC. IN RECENT MONTHS BIG SPRINGS HAS TAKEN SIGNIFICANT STEPS TO IMPROVE THE SURGERY UNIT. THE BIG SPRINGS FACILITY HAS HIRED A BOARD CERTIFIED CHIEF OF SURGERY, 2 BOARD CERTIFIED GENERAL SURGEONS, A BOARD CERITIFIED UROLOGIST, AND IS CURRENTLY NEGOTIATING WITH AN ANESTHESIOLOGIST. IT HAS BEEN YEARS SINCE BIG SPRINGS LAST HAD AN ANESTHESIOLOGIST. HOWEVER, SIGNIFICANT PROBLEMS REMAIN IN THE SURGICAL UNIT. IT STILL CONTAINS ORIGINAL, 1950s VINTAGE EQUIPMENT AND THERE ARE SIGNIFICANT STRUCTURAL INEFFICIENCIES IN THE SURGICAL WING (FOR EXAMPLE, THE ARCHITECTURAL FAILURE TO PROVIDE SEPARATE CORRIDORS FOR STERILE AND SOILED MATERIALS). IN ADDITION, THE SUPPLY, PROCESSING, AND DISTRIBUTION (SPD) UNIT IS OUTMODED AND UNDERSIZED FOR CURRENT NEEDS. IT IS NOW NECESSARY FOR THE DEPARTMENT TO PROMPTLY COMMIT TO THE MINOR CONSTRUCTION PROJECTS NECESSARY TO CORRECT THESE TWO DEFICIENCIES. THE VAMC HAS DONE ALL IT CAN TO IMPROVE THE UNIT SHORT OF CONSTRUCTION AND A FAILURE TO ACT IN A TIMELY MANNER ON THESE NECESSARY PROJECTS THREATENS TO UNDO THE PROGESS MADE TO DATE. I WANT TO TAKE THIS OPPORTUNITY TO EMPHASIZE MY INTEREST IN THE TIMELY APPROVAL OF THESE CONSTRUCTION PROJECTS.

TESTIMONY OF THE HONORABLE RON MARLENEE (R-MT)

Mr. Chairman, the situation facing veteran health care has reached crisis proportions. It is simply outrageous that some service-connected veterans have been turned away from necessary health care at VA hospitals. It is even more atrocious that veterans are receiving notices in the mail informing them that they only have a 30 day supply of medication left, and then the VA wishes them God-speed as these veterans try to fill their prescriptions. This must end!

I am most concerned about the veterans of Montana. The Big Sky Country has a population of slightly more than 800,000 people and has the third highest per capita veteran population in the United States. More than 106,000 veterans are in Montana, which means that one out of every eight Montanans is a veteran.

In World War II, Korea, and Vietnam, Montana had one of the highest rates for volunteers. However, over the past several years, Montana has received one of the lowest health care expenditures per veteran in the United States. Today, because of restrictive budgets, former prisoners of war who now live in eastern Montana are no longer able to receive care as outpatients. Over 700 veterans have been given a 30 day supply of medicine and turned out to seek help wherever they can find it.

The VA Medical Centers at Miles City and Helena have had to close wards and restrict inpatient care to Category A veterans and outpatient care to Priority One veterans. Both Medical Centers had to take these measures just to survive the next few months, and the President's proposed Fiscal Year 1990 budget does not offer much relief. In fact, it CUTS spending on hospitals and health care by $100 million to $11.1 billion. This is a slap in the face of all veterans.

Mr. Chairman, all I want is fairness for veterans. We've asked them to give up a portion of their lives defending this great land. The least we can do is to honor the promises made to them that we would provide for their health care. I am asking you to propose stable, recurring funding that is fair for the rural Montanan veteran.

In Montana, more than 80 percent of veterans live over 100 miles from a VA Medical Center. Although several veterans' groups have volunteered time and money to provide transportation to Miles City, being able to reach a VA hospital is not enough. The Medical Centers must have the money to pay for medications, blood, food, and supplies. These Montana facilities do not have enough money in their recurring budgets to pay for direct patient care items needed to provide the quality of care veterans expect and deserve to have.

The VA centers in Montana have gone the extra mile to efficiently manage the meager resources allocated to them. But, they can't do it alone -- Congress must provide equity of funding for the medical care of Montana veterans.

Currently, the VA Medical at Miles City needs approximately $1.1 million to survive this fiscal year to treat those veterans mandated by law. The VA facility at Fort Harrison faces a $1.7 million shortfall. While this may be small by big city standards, this has a harsh impact over this large geographic area. The Miles City VA hospital alone serves a veteran population in an area the size of the state of Nebraska.

Over the past few years, the pencil-pushers at the Office of Management and Budget appear to have had their own agenda -- deficit reduction at the expense of veterans. The previous Administration kept assuring Congress that there was sufficient money in the VA system to care for veterans. The hearings held by this Committee last September proved that many VA medical facilities were woefully short of funds.

However, it's now time to stop name-calling and finger-pointing. It's time to plug the shortfall at the Veterans' Administration as soon as possible. I respectfully request your Committee, Mr. Chairman, to approve an emergency supplemental appropriation before something tragic happens. I would also recommend the Committee reject former President Reagan's budget priorities for the VA health care system, and instead authorize $12.77 billion for veterans' medical programs as suggested by various veterans' service organizations.

Simply put, Mr. Chairman, authorizing $11.1 billion will only exasperate the shortfall in funding. VA hospitals need an extra $1.6 billion not only to close the immediate shortfall but to catch up for inflation and the "cannibalization" of the veterans programs that is going on all across America. Veterans have been waiting since last November for an answer to this problem. I think we owe it to them to get money out to VA centers -- now!

To quote an American poet, Robert Service, "A promise made is a debt unpaid." The American veteran has been promised that he would be cared for in his old age, and in his infirmities. Mr. Chairman, I simply want that promise fulfilled. Thank you for your indulgence.

STATEMENT OF THE HONORABLE MICHAEL BILIRAKIS
FEBRUARY 1, 1989

MR. CHAIRMAN, THANK YOU FOR CALLING THIS HEARING IN ORDER TO DISCUSS THE PROPOSED BUDGET FOR THE DEPARTMENT OF VETERANS AFFAIRS FOR FISCAL YEAR 1990.

IN ALL HONESTY, I MUST VOICE MY CONCERNS OVER THE DRASTIC SHORTCOMINGS IN PROPOSED BUDGET AND SPECIFICALLY IN THE PROPOSED MEDICAL CONSTRUCTION BUDGET. EVERY YEAR, THE VETERANS ADMINISTRATION PROPOSES, AND THE OFFICE OF MANAGEMENT AND BUDGET SLASHES. FOR THIS FISCAL YEAR, THE V.A. REQUESTED FUNDING FOR THE 120 BED NURSING HOME IN LAKE CITY, FLORIDA, AND OMB REJECTED FUNDING FOR THIS MUCH-NEEDED FACILITY. FUNDING FOR THE PROPOSED 290-BED LONG-TERM PSYCHIATRIC FACILITY IN GAINESVILLE, FLORIDA FOR WHICH I APPLAUD THE VETERANS ADMINISTRATION'S REQUEST, WAS ALSO REJECTED BY OMB. IN ADDITION, I MUST ASK, WHAT HAS HAPPENED TO THE SLATED HOSPITAL FOR EAST CENTRAL, FLORIDA? I MUST SAY THAT MARCH 15, 1989, THE EFFECTIVE DATE FOR THE ESTABLISHMENT OF THE DEPARTMENT OF VETERANS AFFAIRS, WILL NOT COME SOON ENOUGH IN THIS MEMBER'S OPINION. ONCE A CABINET LEVEL DEPARTMENT, SECRETARY-DESIGNATE, EDWARD DERWINSKI, WILL ADVOCATE FOR AMERICA'S VETERANS AND CHALLENGE OMB'S ARBITRARY BUDGET CUTS.

THE VETERANS ADMINISTRATION REQUESTED APPROXIMATELY $950 MILLION FOR THE UPCOMING FISCAL YEAR FOR THE MEDICAL CONSTRUCTION BUDGET BUT OMB SLASHED THAT REQUEST IN HALF. THIS IS OF DEEP CONCERN TO ME IN LIGHT OF THE RECENT VA CAPITAL FACILITIES STUDY (CFS). THAT STUDY ESTIMATES THAT $1.45 BILLION IN CONSTRUCTION COSTS

WOULD BE REQUIRED TO CORRECT THE DEFICIENCIES IN THE FACILITIES NATIONWIDE. I DO NOT NEED TO EMPHASIS THE OBVIOUS FACT THAT THE DETERIORATION OF VA FACILITIES HAS A PROFOUND AFFECT ON THE QUALITY OF HEALTH CARE DELIVERY TO VETERANS. THE DECREASE IN FUNDING FOR THE MEDICAL CONSTRUCTION BUDGET AND SPECIFICALLY THE $41.5 MILLION DECREASE IN FUNDING FOR NURSING HOMES ARE TROUBLESOME IN VIEW OF THE CAPITAL FACILITIES STUDY.

THE NEED FOR NEW CONSTRUCTION AND REPLACEMENT FACILITIES IS MOST APPARENT IN THE STATE OF FLORIDA WHERE 1.5 MILLION VETERANS RESIDE. 15,000 VETERANS MOVE PERMANENTLY TO FLORIDA EVERY YEAR. THIS IS A GREATER GROWTH RATE IN VETERAN POPULATION THAN ANY OTHER STATE IN THE COUNTRY. THE GROWING NUMBER OF AGING VETERANS IN FLORIDA ALSO POSES A PARTICULAR HEALTH CARE PROBLEM FOR THE VETERANS ADMINISTRATION AND ONE WHICH MUST BE RESOLVED IMMEDIATELY. NINE PROJECTS IN FLORIDA WHICH WERE SLATED BY THE VA FOR INITIATION IN FY90 AT A COST OF $282 MILLION WERE POSTPONED.

IT IS WELL KNOWN BY MEMBERS OF THIS COMMITTEE THAT I FEEL THE VA BUDGET HAS BEEN A VICTIM OF SHORTSIGHTED BUDGET CUTS. I CERTAINLY DO NOT BELIEVE IT IS ACCEPTABLE TO BALANCE THE FEDERAL BUDGET ON THE BACKS OF VETERANS, NOR DO THE MAJORITY OF MY COLLEAGUES. WE MUST BE CAUTIOUS IN THE ALLOCATION OF VA RESOURCES AND PROVIDE VA SERVICES AND BENEFITS WITHIN THE BEST OF OUR ABILITY.

PAGE 3

WITH REGARD TO THE OVERALL VA BUDGET FOR FY90, THE ADMINISTRATION'S BUDGET REQUESTS $28.6 BILLION IN APPROPRIATIONS FOR EXISTING PROGRAMS. THIS WILL NOT PROVIDE ADEQUATE FUNDING FOR CURRENT SERVICES. AS WE ALL KNOW, CURRENT FUNDING IS INSUFFICIENT THE SYSTEM IS PLAGUED WITH STAFF SHORTAGES, TERMINATED SERVICES AND OTHER PROBLEMS WHICH HAVE LED TO THE TURNING AWAY OF VETERANS. IT IS PREDICTED THAT THE VA WILL SUFFER A $1 BILLION SHORTFALL IN FISCAL YEAR 1990.

I ALSO HAVE CONCERNS REGARDING THE PROPOSAL TO CHARGE 0% TO 20% SERVICE-CONNECTED DISABLED VETERANS FOR NONSERVICE-CONNECTED HEALTH CARE, AND (1) TO HAVE NONSERVICE-CONNECTED VETERANS IN HIGHER INCOMES AND (2) THOSE CATEGORY C PENSION VETERANS IN HIGHER INCOMES PAY COPAYMENTS.

IN CLOSING, I WISH TO TOUCH UPON A POSITIVE BUDGET PROPOSAL -- THAT BEING THE $112 MILLION FACILITY AT PALM BEACH, FLORIDA. THIS FACILITY IS LONG OVERDUE AND I AM PLEASED THE VA REQUESTED ITS FUNDING.

THANK YOU MR. CHAIRMAN.

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

MAR 14 1989

Honorable G. V. (Sonny) Montgomery
Chairman, Committee on Veterans Affairs
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Enclosed are the responses to the questions from the Hospitals and Health Care Subcommittee Hearing held on February 1, 1989. The responses are to questions you submitted in your letter, dated February 7, 1989, to Ms. Susan Livingstone on behalf of Honorable Tommy F. Robinson, Honorable Timothy J. Penny, Honorable Charles W. Stenholm, Honorable Lane Evans, Honorable Marvin Leath, Honorable Jim Jontz and yourself.

Also, enclosed are responses to questions you submitted to Ms. Livingstone on behalf of Honorable Bob Stump in a letter dated February 8, 1989.

Please let me know if we can be of further assistance.

Sincerely yours,

Edward J. Derwinski
Administrator

Enclosures

CHAIRMAN MONTGOMERY TO VETERANS ADMINISTRATION

Question: 1. Two of the six VA AIDS Research Centers required Funds in the amount of $2.5 million each for containment facilities to handle the HIV virus safely. What is the status of these facilities: When will these be funded?

Answer: The design funds have been allotted to both AIDS centers (San Diego and New York) to hire an Architectual Engineering Firm to design the containment facility. The current estimated total project cost for the San Diego facility is $1.3 million and for the New York facility, $1.8 million.

The project designs are expected to be completed by the end of FY 1989 or early 1990. The selection of minor projects to be funded in FY 1990 for either design and/or construction will be accomplished by May 1989. Funding of these specific projects will depend upon system-wide priorities and budget resources.

Question: 2. The VA's Capital Facilities Study gave both the Newington, CT, and Waco, TX, VA facilities a rating of good. Yet, they are included in the fiscal year 1990 budget request and are described as having "serious space and functional deficiencies" or "significant problems with major building systems." How do you reconcile the ratings with the budget request?

Answer: The Capital Facilities Study (CFS) is a comprehensive technical assessment of the physical plant of a VAMC. The purpose of the study is to assess the physical condition of the buildings, support systems and utilities using current codes and standards. The CFS does not assess departmental space deficiencies or functional relationships between departments and services.

Both VAMC Newington and VAMC Waco received an overall rating of good, but assessments of individual buildings and support systems indicate deficiencies that will require correction. These deficiencies, such as the lack of sprinkler systems, inadequate heating, ventilation, and air conditioning systems, presence of asbestos, inadequate automatic transport systems, etc., are "the significant problems with major building systems" being referred to in the budget submission.

Question: 3. Your prepared testimony stated that before requesting additional VA nursing home beds a "thorough assessment" will be completed. Please tell us about that assessment, including the estimated completion date.

Answer: As part of the FY 89 planning cycle, the Nursing Home Care Planning Projection Model has been updated to incorporate 1985 survey results from the National Center for Health Statistics (NCHS). The need for all proposed VA Nursing Home beds will be reviewed during this process. A community survey is required which assesses the availability and suitability of nursing home beds in Community and State Home Nursing Home facilities in the Primary Service Area (PSA) where the additional VA nursing home beds are proposed. Those facilities requesting additional VA nursing home care beds will submit their assessment along with their MEDIPP Strategic Plan submission to VA Central Office by July 30, 1989. Final decisions on the need for new VA owned and operated nursing home beds will be made prior to the submission of the VA's FY 1991 budget. If nursing home beds are justified they will be considered during the development of the FY 1991 budget.

Question: 4. What outpatient facilities are scheduled for construction in the fiscal year 1990 budget?

Answer: The fiscal year 1990 budget includes the following major construction projects that incorporate outpatient facilities for VA medical centers (dollars in thousands):

Location	Description	FY 1990 Request	Total Cost	Constr. Award Date
Dublin, GA	Outpatient Clinic Addition	$ 9,500	$ 9,500	7/90
Newington, CT	Medical Center Modernization	53,745	59,000	4/90* 9/90*
Palm Beach, FL	New Medical Center	112,025	138,100	9/90
Salt Lake City, UT	Renovate Building 1	26,600	26,600	8/90

*The first date is for Phase I; the second date is for Phase II.

Question: 5. What are the ten outpatient clinics which would be funded in fiscal year 1990 if money were made available for them?

Answer: We are currently projecting the use of FY 1990 leasing funds for new satellite outpatient clinics as follows:

Location	Funds Required
1. Austin, TX	Initiation of rent
2. Bakersfield, CA	Award funding (lump sum)
3. Ft. Worth, TX	Initiation of rent
4. Lufkin, TX	Initiation of rent
5. Mount Vernon, MO	Adjustment of rent to incorporate full year cost
6. Ocean County, NJ	Initiation of rent
7. Quad Cities, IA/IL	Award funding (lump sum)
8. San Jose, CA	Award funding (lump sum)
9. Savannah, GA	Adjustment of rent to incorporate full year cost
10. Superior, WI	Adjustment of rent to incorporate full year cost
11. Tallahassee, FL	Award funding (lump sum)

Question: 6. The Veterans Administration testified that payments for the Savannah Outpatient Clinic will start in September, 1989. What will be the amount of the monthly payment?

Answer: The monthly payment will be $29,218.96 fully serviced. However, the contractor has been granted an extension until September 15, 1989, to complete the clinic space so the amount of rent paid in September 1989 will be pro-rated from the date of acceptance.

Question: 7. If the equipment for the Savannah Outpatient Clinic is ordered now, what date would you anticipate the Clinic would be operational for the treatment of patients?

Answer: Approximately six months lead time is necessary, after purchase orders are processed, to account for ordering, receipt and installation of equipment.

HON. BOB STUMP TO VETERANS ADMINISTRATION

Question: 1. Why was the Palm Beach, Florida, nursing home project eliminated from the FY 90 budget?

Answer: Nursing home care beds for the proposed new VA medical center in Palm Beach, FL were not requested by VA nor included in the FY 90 Reagan's budget because, during the budget negotiations for the FY 88 President's budget, it was determined that nursing home needs could be met through the more cost efficient community and state home programs.

Question: 2. What are the VA's plans for conversion of hospital beds to nursing home beds for FY 90; how many were actually converted in FY 88; how many have been converted this year; how many will be converted by this coming October.

Answer: The current projection is that 207 beds will be converted from hospital beds to nursing home beds in FY 90. In FY 88, 143 beds were converted from hospital to nursing home beds. To date, in FY 89, there have been 154 hospital beds converted to nursing home beds and it is now projected that by October a total of 407 hospital beds would be converted in FY 89.

Question: 3. How long does it currently take, from start to finish, to build a major VA construction project? How long should it take?

Answer: Once a project has completed preliminary development and is funded for construction, the work required to design and build a typical major construction project takes approximately four years. This does not include projects in the Replacement and Modernization category. The preliminary development time may vary considerably due to several factors such as agency-wide priorities, budget constraints and medical program planning (MEDIPP) changes.

Once a project has been funded for design and construction, the tasks required to complete the project include: working drawing design (one year), bidding (four months) and construction (2 1/2 years). Four years is a reasonable amount of time to complete the required design and construction of a typical major project.

As a federal agency, it should be noted that the VA's design and construction requirements are driven by a number of factors which do not affect private sector builders. Such factors include statutory and regulatory requirements governing A/E and construction contractor selection, prohibitions against the use of brand name or proprietary specifications which then require lengthy reviews of shop drawings, and federal budget approval cycles.

Question: 4. Please explain the rationale behind the proposed legislation to increase the minor construction limitation from $2 million to $3 million. Was the decision purely based on the need to stay current with inflation, or were other factors considered? Will these proposed limitation increases adversely affect any on-going construction projects or cause slippage of projects?

Answer: The VA's proposal to increase the minor construction limitation from $2 million to $3 million was primarily based on the need to stay current with inflation. While inflation is indeed the primary element in the request for an increase in the minor construction limitation, inflation itself is not the driving force, program efficiency is. The trend towards planning a project into multiple smaller projects or phases, each with its own distinct identity is becoming more prevalent in order to keep within the current $2 million limitation. Each of these projects or phases requires the full administrative process from inception to completion. Increasing the minor construction limitation to $3 million would help reduce the possible need for multiple projects or phasing and in turn reduce the administrative costs.

The $2 million limitation has been in effect since FY 1981. During this period, the Boeckh index rose 33.9 percent based on the national average. The Boeckh index measures the inflation rate for construction projects and is used in the VA's annual budget for converting the construction appropriations and outlays to constant dollars. The increase in this index means that a building that cost $2 million in FY 1981, now costs approximately $2.7 million. By FY 1990 when the $3 million limitation will be in effect, the Boeckh index is expected to have risen by 43.7 percent (using OMB inflation allowances), and a project that cost $2 million in FY 1981 will cost approximately $2.9 million by then.

The proposed limitation increase will not cause slippage of on-going construction projects. On-going or funded construction projects will continue to be accounted for in their originally designated appropriation. For example, a funded major project, whose total estimated cost is $2.5 million, will still be treated as a major. The proposed change will not affect the schedules of minor projects. However, if this proposed legislation is not passed for FY 1990, it may delay projects that are estimated to cost between $2 million and $3 million which are tentatively being planned as a minor project. Such projects would then be subject to at least a year's delay because of the need to request them as a major prospectus-level project.

Question: 5. A substantial level of funds is requested for the asbestos abatement program in FY 90. When is it anticipated that this will be completed?

Answer: Asbestos was used extensively in a wide variety of buildings until the late 1960s. Most of our VA hospitals were built before this period and, consequently, contain substantial amounts of asbestos containing products. It is the general consensus of most experts in the field of asbestos abatement that if the asbestos is in good shape and is enclosed by a physical barrier i.e., pipe shafts or ceilings, that the best solution is to identify the asbestos and to leave it in place. All VA facilities have conducted asbestos surveys to identify asbestos and, in general, have identified all asbestos. However, as part of the VA's Asbestos Abatement and Management Program (Circular 00-88-6, February 10, 1988), VA facilities are upgrading the quality and accuracy of their asbestos surveys in FY 1989 through the Non-recurring Maintenance program.

VA policy regarding asbestos abatement requires that all asbestos that imposes an immediate health risk be removed immediately. This has already been done. However, this comprises a very small amount of the asbestos products in our VA medical centers.

VA policy regarding the remaining asbestos requires that it be removed in conjunction with an ongoing renovation project. In other words if the VA is considering a renovation project, then all the asbestos within the scope of that renovation project will be removed as part of that project. Consequently, it will be many years before all the asbestos is removed from VA buildings; however, we feel that this is the prudent approach.

Question: 6. If future funding may not be forthcoming (in light of priorities on providing health care), why is $700,000 in the Advance Planning Fund and $600,000 for Design included in the FY '90 Budget Request for the Veterans Benefits Administration colocation projects? Do funds in the amount of $2 million requested in Minor Construction for renovation and modification to existing VBA Regional Office space include any offices which may have to colocate?

Answer: Although no Major Construction funds are included in the FY '90 request for colocation projects, Veterans Benefits Administration has identified 10 regional offices as potential colocation projects for development and design over the next five years. Advance planning funds are required for designing and developing prospective colocation projects. The design development phase results in improved functional and scope definitions as well as providing reliable cost estimates. After the completion of project schematics and the design development phase, design funds are required for accomplishing all of the activities necessary to prepare contract documents. FY 1990 Advance Planning Funds of $700,000 will be used to accomplish all project design work through the design development phase. Two colocation projects are currently planned for FY 1990 advance planning: Boston, MA; and St. Petersburg, FL.

The $600,000 for the FY 1990 design fund would be used to support the design of contract documents for those major colocation projects approved in the FY 1991 budget request.

No renovations and modifications to existing office space will be accomplished in any regional office which Congress has approved construction funding for building a colocated facility.

HON. CHARLES W. STENHOLM TO VETERANS ADMINISTRATION

Question: I would like to know the current status within the department's approval process of the minor construction projects for a new surgical wing and SPD unit at Big Spring VAMC?

Answer: Two minor construction projects have been submitted; one to expand Supply Processing and Distribution and the other to construct a new surgical suite. Both projects have been included in the list of projects proposed for funding in the FY 1990 budget. The funding for these two projects will be based on system-wide priorities and the availability of resources.

Question: In the Capital Facilities Study recently completed by the VA, the Big Spring VAMC received an overall rating of -1 indicating that facilities, including the elevator system, were in need of replacement within 2-3 years. More specifically, the study gave the main building at Big Spring a -2, indicating that the HVAC (heating and air conditioning), plumbing, sanitary and electrical systems need to be replaced in the next 1-2 years. In spite of these structural problems, Big Spring VAMC has made heroic efforts to keep delivering services. These efforts were recently noted by the Department of Energy which awarded Big Spring with its Energy Efficiency Award. However, the study lays out specific problems and I would like to know what plans the VA has for addressing these and the other needs at Big Spring cited in the study?

Answer: The major issues cited by the study will be corrected by a series of projects as follows:

- A major construction project is proposed for Advanced Planning Fund design approval in FY 1991 and construction in FY 1994 to correct the heating, ventilating and air conditioning deficiencies.
- A series of non-recurring maintenance projects have been approved in FY 1989 to take care of plumbing and sanitary deficiencies and the replacement of elevators.
- A major construction project was completed in May 1987 to correct electrical distribution systems deficiencies.

The facility is scheduled for a Facility Development Plan as part of the second group of medical centers selected for this very comprehensive planning process. One of the products of the process will be the determination of facility deficiencies needing correction and a plan to accomplish them.

HON. JIM JONTZ TO VETERANS ADMINISTRATION

At the present time a $33 million, 240 bed Geropsychiatric Building at the Marion, Indiana, VAMC is in the planning stages.

It is my understanding that the preliminary designs are about 50% completed. The VA has asked for money in the FY 90 budget for working drawings. I have been informed that the proposed long term schedule calls for construction to begin in FY 1991, with completion scheduled in the summer of 1994.

Question: 1. What priority does the Department give to the construction of this facility? If priority is unknown, when will the priority for this facility be assigned? Briefly describe the methodology used to assign priority for this facility. Describe the need for this facility, and other alternatives within the VA hospital system to provide this care. Please describe when this VAMC will next be assessed.

Answer: This project has received a high priority score of 15.33. The VA Construction Prioritization Methodology is a state of-the-art decision support tool which establishes a priority score for each project based on key weighted factors identified as critical to judging the importance of particular types of deficiency correction. These factors include space and functional deficiencies, service levels, age and physical condition and degree of non-compliance with established codes.

The proposed project will replace the current structure, built around 1889, which houses long-term psychiatric patients. These buildings have serious space and functional deficiencies and lack patient privacy. This project allows for consolidation of the Medical Center complex and provides an enhanced environment to care for these types of patients. The preliminary design contract for the project was awarded in May 1988 and the project will be a consideration for construction funding in the FY 1991 budget cycle. The project was not included in the FY 1990 request because the preliminary design was not complete. Should the project be selected for FY 1991 construction funding, the working drawing design would be funded from the FY 1990 design fund.

Question: 2a. An outpatient clinic has recently opened in Crown Point, Indiana. I understand that it has not been possible to project future patient load because of the newness of this facility. Please describe any contemplated construction at this clinic, even if such a projection would be tentative in nature.

Answer: There currently is no additional construction planned for this Crown Point facility.

Question: 2b. Describe what will be done to monitor patient load so as to be responsive to future patient needs.

Answer: The Region will be closely monitoring the workload at the Adam Benjamin Jr. Outpatient Clinic (ABJOPC) in Crown Point, Indiana. The VA Medical Center, Chicago (Lakeside), Illinois, parent facility to the Crown Point, Indiana outpatient clinic, recently implemented actions to limit the numbers of new Category B and C veterans accepted for care and to evaluate the need for continued outpatient services to Category B and C veterans presently being treated at the clinic. These initiatives are consistent with system-wide initiatives to correct regional inequities in access to care.

HON. LANE EVANS TO VETERANS ADMINISTRATION

Question: 1. Are all facilities rented by the VA for regional offices in good repair and completely satisfactory? What deficiencies exist? What repairs or improvements are needed?

Answer: Not all facilities rented by the VA for regional offices are in good repair and completely satisfactory to our standards for sound operating environments. Generally, the principal areas of concern involve inadequate heating, ventilation and air conditioning of our office areas. In addition, we continue to experience delays in some renovation and alterations projects which adversely impact our ability to operate in an efficient manner. In order to correct these deficiencies, we continually work with the General Services Administration to rectify and improve out-of-line conditions.

Question: 2.a. In May 1987, the Deputy Chief Benefits Director for Field Operations appeared before the Oversight and Investigations Subcommittee. According to his testimony, the VA was, "Progressing positively toward a successful program of colocating regional offices on medical center property...". Please give us examples of "positive progress" being made toward a "successful program of collocating regional office" on medical center grounds?

Answer: Regional offices are being considered for potential colocation sites based on our review of their feasibility and cost-effectiveness. For example, we have colocated two regional offices during the past three years, Little Rock, Arkansas and Milwaukee, Wisconsin and are planning to colocate the Wichita, Kansas regional office during FY 1991 when construction is scheduled to be completed. In addition, we have identified 10 regional offices as potential colocation projects for development and design over the next five years. The scope and the proposed funding year of each colocation project is tentative and could be affected by changing space needs, budgetary considerations and the priorities of the Department's overall construction program.

This initiative experienced slippage during the 1989 and 1990 fiscal years. Our fiscal year 1989 budget request included funds for the Montgomery colocation project and slipped when construction funding was not included in the appropriation language. Colocation projects were not included in our FY 1990 budget request due to budgetary constraints and other priorities of the agency's overall construction program. As a result of these actions, the colocation schedule has been revised for Fiscal Years 1991 through 1995:

1991	1992	1993	1994	1995
Montgomery	Boston	Cleveland	Newark	Chicago
Hartford	St. Petersburg	Columbia	Houston	Winston-Salem

Question: 2.b. Is colocation a "successful program" today and how is that success measured? Please identify any measurable goals which have been established for this program?

Answer: While we have not had enough experience to fully evaluate the benefits of colocation in order to determine whether it's a "successful program", in Little Rock, Arkansas, we have experienced immediate benefits in the reduction of rent costs and shorter response time for adjudication cases requiring medical reviews and/or examinations. In addition, colocation has virtually eliminated mail delays and has afforded the opportunity for establishing a closer working relationship between the medical staff and adjudication division personnel, thus facilitating consultations during comprehensive reviews and assessment of medical information related to veteran claims.

Question: 3. What is the current official policy of the VA on colocation?

Answer: Planning for colocation of Veterans Benefits Administration regional offices onto existing Department-controlled grounds continues to be pursued as an alternative for housing VBA employees and functions. Under certain conditions, colocation can be a positive means of delivering benefits and services to veterans and their beneficiaries. While the Department is committed to an aggressive schedule for the development of colocation projects where cost effective, their inclusion in the major construction budget submission, for a particular fiscal year, is affected by budgetary constraints and the priorities of the Department's overall construction program.

Colocation projects will be submitted to the Congress as soon as our review of their cost-effectiveness and feasibility is completed. This review involves consideration of factors such as building location, access for veterans, dependents and employees and impact on GSA's ability to backfill current VA leased space.

CAPITAL FACILITIES STUDY

Question: 1. The initial Capital Facilities Study has been completed for 132 medical centers. How frequently will this data base be revised, how will it be revised and what will it cost to update this data base?

Answer: The data base is being updated annually. Presently, the data is revised through a manual process. In this process the medical center staff sends a marked up hard copy of the data base to the Office of Facilities staff for data entry into the computer. This process is considered a temporary solution. The VA Office of Facilities is investigating electronic updating as a permanent solution. In the electronic updating process the medical center staff will update their data base electronically from the medical center. The data base, however, will continue to reside in the VA Office of Facilities' computers. The electronic process has been tested at VA medical centers in Albany, NY, and Northampton, MA. These pilot tests were successful. A report on the costs of implementing an electronic updating process as well as the costs of the current manual updating process is being prepared by the VA Office of Facilities' staff. This report is anticipated to be available in late April.

Question: 2. Under an expanded Capital Facilities Study, medical centers constructed after 1970 and selected Department of Memorial Affairs facilities are proposed to be analyzed. Will any DVB facilities be analyzed? If not, why not?

Two uses of the Capital Facilities Study data base are identifying physical plant deficiencies and prioritizing construction projects. Does a data base of regional office physical plant deficiencies exist? Wouldn't a data base of regional office plant deficiencies be useful especially regarding collocation priorities? How much would such a study cost?

Answer: The VA does not have a data base of regional office plant deficiencies. Most DVB facilities are leased from GSA. As such, it is GSA's responsibility to assure the condition of the physical plant. It is our understanding that GSA periodically performs an evaluation, similar to our Capital Facilities Study, for the buildings it owns. Attached for your information is a letter dated June 10, 1988, to GSA detailing deficiencies at four DVB leased facilities. At the sites where DVB facilities are colocated, the VA is in the process of building a data base as a part of the medical centers' capital facilities studies and Facility Development Plans.

In terms of selecting projects for colocation, DVB considers a number of factors including operational efficiencies, site/building availability at VA medical centers, the working environment and physical plant of the existing leased Regional office space, and what the most cost effective means of providing Regional office space is.

Question: 3. Why have one-third of the Capital Facilities Study identified deficiencies not been included in 5 year medical center plans?

Answer: The Agency's analysis of identified deficiencies at the completion of the studies indicated that 12 percent of the deficiencies have either been corrected or funded for correction. In addition, 66 percent have been planned for correction in the medical centers' 5 year plans. At the time of the analysis, 22 percent had not been identified for correction in the medical centers' 5 year plans. Since that time, as plans are updated by medical centers, the correction of these deficiencies are being incorporated into these plans. When all medical center plans have been updated, all needed corrections will be included in these plans.

Question: 4. If MEDIPP priorities and Facility Development Plan priorities are not the same, how should these differences in priorities be resolved? Will MEDIPP become obsolete?

Answer: The Facility Development Plan process is based on MEDIPP and, as such, does not replace MEDIPP but rather is responsive to it.

The Medical District Initiated Program Planning (MEDIPP) is the decentralized planning process for the Department of Medicine and Surgery (DM&S). This program planning process enables DM&S to respond to changing environmental influences, to deliver a balanced array of appropriate services, and to assure veteran access to medical programs while maintaining a high standard of health care. MEDIPP has two major components: Strategic plans which include Long Range Needs Assessments producing the total numbers of beds and outpatient visits and Strategic Five Year Planning designed to identify program changes which can be realized in the next five years considering the realities of budgetary decisions; and, One-Year Implementation Plans which identify actions that can be implemented within a one-year period and provide the basis for implementing high priority MEDIPP initiatives. MEDIPP establishes the programmatic needs of the Department.

The Facility Development Plan (FDP) is the Agency's collaborative planning process for the development of appropriate facility construction planning to respond to the programmatic needs of the Department of Medicine and Surgery, the Department of Veterans Benefits and the Department of Memorial Affairs. Each FDP is based on current and projected program planning and technical requirements and results in a selected facility development strategy and logical groupings of construction activities to meet the strategy, needs and deficiencies identified for each VA facility. The FDP process responds to and is driven by the program planning (MEDIPP) of the Department of Medicine and Surgery and, as appropriate, the planning processes of the DVB and DMA. The FDP process is based on the strategic information provided by MEDIPP (long range projections of bed levels and outpatient workload) as well as the program planning identified to expand or establish specific program initiatives requiring facility improvements in the Strategic Five Year Planning and the One-Year Implementation Plans. Priorities included in the FDP, therefore, will follow the program planning priorities established by MEDIPP.

The FDP will be used to prepare specific construction projects included in the Five-Year Facility Plan at the local level; the district and regional construction plans at their respective levels; and, will eventually be used to assist in the identification and budgeting of specific construction projects at the national level (major, minor, minor miscellaneous, non-recurring maintenance, parking revolving fund, and nursing home revolving fund).

The FDP process will not make MEDIPP obsolete. The FDP provides the strategic facility planning link between MEDIPP program planning and the identification, budgeting, and implementation of specific construction projects.

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

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JUN 10 1988

In Reply Refer To:

Mr. John Alderson
Acting Administrator
General Services Administration
18th and F Streets, NW
Washington, DC 20405

Dear Mr. Alderson:

Over the past years, the VA (Veterans Administration) and GSA (General Services Administration) have worked successfully in a number of cases to provide quality workplace environments for the VA to carry out its mission. The working relationships between our staffs are positive in such places as Indianapolis, Indiana; Los Angeles, California; Pittsburgh, Pennsylvania; Roanoke, Virginia; and Winston-Salem, North Carolina.

Unfavorable conditions continue to exist, despite the best staff efforts, which adversely impact operations. Because of this, your support in resolving issues in the following localities is requested:

Baltimore, Maryland
Jackson, Mississippi
San Francisco, California
St. Petersburg, Florida

A brief description of the issues at each location is enclosed. Questions may be directed to Mr. Thomas R. Wagner, Chief, Space, Procurement and Work Measurement Staff (201B), on 233-3021.

We wish to emphasize the need to correct these workplace issues to the satisfaction of both our organizations. Your cooperation and assistance are appreciated.

Sincerely,

THOMAS K. TURNAGE
Administrator

Enclosure

"America is #1—Thanks to our Veterans"

GSA/VA ISSUES

1. Baltimore, Maryland

a. Location: G. H. Fallon Federal Building
31 Hopkins Plaza
GSA Building No.: MD0055ZZ

b. Development, implementation and completion of space alteration plans have been on-going difficulties since 1984. Since April 1988, the location of child care facilities has become an issue because of the building's major tenant (IRS) proposing to GSA the displacement of VA public contact activities from their present location on the first floor without discussing it with VA officials. VA Central Office has not been officially notified by GSA of the planned implementation.

2. Jackson, Mississippi

a. Location: Dr. A. H. McCoy Federal Building
100 W. Capitol Street
GSA Building No.: MS0083ZZ

b. VA elements, located on what is known as the "B" section of the second floor, have inadequate air treatment (extreme cold in winter and heat in summer) because of the building design. After many discussions with and letters to GSA, the only acceptable solution is the relocation of the VA activities. The problem is the lack of available space to relocate within the federal building.

3. San Francisco, California

a. Location: 211 Main Street
GSA Building No.: CA4970ZZ

b. Since October 1986, planning, development and implementation of a space alternation project to reduce space by 25,000 square feet has not been completed. Inaction by the building owner in addressing city code requirements has stalled the project.

c. This regional office is to be relocated to the new Federal Building in Oakland, California in FY 1991.

4. St. Petersburg, Florida

a. Location: William Cramer Federal Building
144 First Avenue South
GSA Building No.: FL0080ZZ

b. Rodent infestation, custodial services, physical security of building, elevator maintenance and telephone installation have been points of difficulty to varying degrees since 1983. Until recently all other tenants were relocated to other sites in the Tampa/St. Petersburg area. A Military Entrance Processing Center was recently relocated to this building because the building they previously occupied was sinking into the Florida landscape. The Cramer Federal Building has been cited by the VA Inspector General's Office as being inadequate for VA operations (A copy of this report was forwarded to the GSA Inspector General).

c. This regional office is under consideration in the Agency's colocation program.

HON. TIM PENNY TO VETERANS ADMINISTRATION

Question: What is the status of construction and activation funding for the Twin Ports Outpatient Clinic in Superior, WI?

Answer: Construction of the Superior OPC is projected to be completed in late May 1989. Activation is scheduled for August 1989. However, a delay in activation could occur given a shortfall in available activation funds in FY 1989.

Question: As you are well aware, there are serious problems as a result of the lack of air conditioning in certain patient areas at the St. Cloud VA Medical Center. What is the status of funding for the project? What is the likelihood of any air conditioning being operational for this summer?

Answer: The need to provide air conditioning for VA Medical Center St. Cloud, MN, has been recognized and projects have been included by the medical center in the facility's five-year plan to meet these needs.

Two projects now funded to air condition patient care areas in Building Nos. 29 and 50 are scheduled for completion in FY 1990. An air conditioning project for Building 2 was approved for FY 87 and was completed in 1988. Future projects call for all remaining buildings containing nursing units to be air conditioned. These future projects are dependent on the system-wide funding priorities and will proceed as soon as funds are available. Currently, one hundred percent of the medical center's clinical areas and approximately 37 percent of the nursing units are air conditioned and will be operational for this summer.

Question: Are there any immediate plans for use of Building 43 at the Minneapolis VA Medical Center?

Answer: In accordance with provision of Section 421(a)(2) of Public Law 100-322, the VA has notified Congress by letter to the House Veterans Affairs Committee of July 5, 1988, and in the FY 1990 request of our intention to excess the building. This decision was based on the results of extensive study. The VA has committed to Chairman Montgomery to provide full justification for the excessing action prior to formally taking any excessing action. This will be done. The Agency's final report on the decision to excess Building 43 was conveyed to the House and Senate Veterans' Affairs Committees and the Minnesota congressional delegation on July 31, 1987.

HON. TOMMY F. ROBINSON TO VETERANS ADMINISTRATION

Question: Ms. Livingstone, attached is a letter from the John L. McCellan Memorial Veterans Hospital outlining their construction priorities for FY 90. Why were these not included in the budget for FY 90?

Answer: The minor and minor miscellaneous projects to be funded during FY 1990 have not yet been identified. That process is underway now. Three of the four projects have been submitted for consideration in the FY 1990 program. The fourth project (UAMS/VAMC Connecting Corridor) is in the facility five-year plan for FY 1991. We expect the review and selection process for projects to be funded during FY 1990 by late spring of this year.

John L. McClellan [redacted]
Memorial Veterans' Hospital Little

Veterans
Administration

In Reply Refer To: 598/00

February 2, 1989

Honorable Tommy Robinson
Member, United States
House of Representatives
1527 Federal Building
Little Rock, AR 72201

Dear Mr. Robinson:

Attached are some of our concerns which we discussed in your recent visit.

We appreciate your interest and support of our medical center.

Sincerely yours,

Jerry Baxter

JERRY W. BAXTER
Acting Director

Enclosure

"America is #1—Thanks to our Veterans"

One of our major concerns is the funding level for VA medical care. During this period of limited resources, we remain committed to the high quality medical care for our veterans. With rapid medical advances, we must continue our efforts to initiate program changes to improve quality care. These changes, while sometimes costly, are necessary for maintaining the standard of care in the medical community.

Another concern is the difficulty in recruitment and retention of senior level physicians. The major difference in VA pay levels with that of the private sector is unrealistic. In some cases, we also have difficulty in recruitment of nurses, pharmacists, therapists, and health technicians. The compensation gap of pay and incentives with the private sector continues to widen. These problems are not restricted to this area, but are systemwide.

Our other local concerns by priority are:

Priority 1 - Ambulatory Surgical Suite

Construction costs	-	$498,000 (estimate)
Equipment costs	-	723,000
Additional staff	-	30 FTEE
Increased recurring funding	-	$1,196,299

Background: This project will provide for the addition of four operating room suites, recovery room, dressing room, patient waiting room, and supply rooms. These rooms will be dedicated to ambulatory surgery and will be placed on the second floor adjacent to the current inpatient surgical suites. The design funds for this project were included in the FY 89 budget for the facility, with proposed construction funding in FY 90.

Priority 2 - Expand Medical/Surgical Cardiology

Additional personnel needed	-	20 FTEE
Additional recurring funding	-	$2,671,520

Background: This proposal has been identified as the facility's top priority in our MEDIPP planning process. Little Rock serves as a district referral center for advanced cardiologic care. This proposal will expand our capacity in cardiac evaluation and surgery. The proposal calls for a two-phase approach. Our yearly capacity for cardiac catheterization procedures will increase from 800 to 1,100. Our open heart surgical procedures would increase from 250 to 350 per year. It would also allow for surgical treatment of arrhythmias.

2.

Priority 3 - Additional CT Scanner

Construction costs - $288,000
Equipment costs - $1,400,000
Additional staffing - 1 FTEE
Additional recurring funds $120,702

Background: The medical center currently experiences significant delays in the completion of diagnostic evaluations of patients due to a backlog in the scheduling of patients for CT scans. An additional scanner will increase our scanning capability and provide for better quality of care.

Priority 4 - Repair Water Infiltration - North Little Rock

Construction costs - $462,000

Background: This project will correct the damages incurred in the interior patient care areas in Building No. 170. Water is penetrating through brick and mortar, the 2,000 windows, thresholds of exterior doors, and the failed roofing membrane.

Priority 5 - UAMS/VAMC Connecting Corridor

Construction costs - $950,000

Background: The original design of the medical center called for a connecting corridor between the UAMS campus and the VAMC. The corridor was to be used for patient movement between the two facilities. Currently, the VAMC and UAMS have sharing agreements covering services for scarce medical specialties. At the present time, patients must be moved by ambulance between the two facilities. With the activation of the Arrhythmia Center, which was funded jointly by VAMC and UAMS, the need for patient movement will increase significantly.

HON. MARVIN LEATH TO VETERANS ADMINISTRATION

Question: A replacement domiciliary (VAMC Temple, TX) is scheduled to be completed in April, yet information I have received indicates that there are no funds to furnish or staff the building once it is completed. I would like to ask if the $1.5 million needed for activation will be included in the construction budget, and if not, that it be included.

Answer: Estimated completion of the Temple, Texas replacement domiciliary is scheduled for June of 1989. Activation funds were not earmarked for activation of this project in FY 1989 due to an existing backlog in activation requirements. However, activation funding for the Temple project will be sought for FY 1990 based upon competing needs and the level of activations funding available to fund projects delayed for activation or only partially funded in FY 1989. In the interim, on-hand equipment and furnishings may be moved from the old domiciliary into the new building later this year to allow for partial activation.

Question: The second project calls for construction of a 300-bed building to house all of the center's acute medical and psychiatry beds. Building 162 was constructed in 1965 as a 240-bed psychiatric facility and currently houses 275 medical, intermediate, and rehabilitation beds. It is a one-story structure with narrow corridors and low ceilings, does not meet current VA space standards or federal handicapped accessibility standards and is not suitable for modern acute medical care.

The existing Psychiatry Buildings 17, 18, and 19 were constructed in 1942. They are two-story buildings of wood-frame construction currently housing 30 beds each on the first floors. Since the Life Safety Code does not permit health care occupancy in a structure of this construction type, a VA equivalency was obtained in 1978 to permit continued use of these buildings if the second floors were kept empty. Since the Joint Commission on Accreditation of Hospitals (JCAH) will not accept a VA equivalency and since JCAH equivalency has not been issued, continued use of these buildings could jeopardize the Center's accreditation.

The VA construction budget includes $14 million for miscellaneous design projects. I would like to ascertain if these funds include design work for the bed replacement project in Temple. The design funds were to be included in the 1989 budget, with construction funds to be included in the following year.

Answer: The FY 1989 design fund does not include the funding for the Temple project. Design funding is normally provided the year prior to the year for which the construction funds are approved. The bed replacement project is presently planned for construction funding in FY 1991 and is, therefore, tentatively included on the FY 1990 design fund list.

CONGRESSMAN RIDGE

Question: 1. Has the VA allocated the necessary construction dollars for the out-patient expansion project at the Erie VAMC to take place in FY 89?

Answer: The outpatient clinic modernization/expansion project has been funded for construction in FY 1989. The construction contract award is currently scheduled for July 1989 with an estimated construction cost of $1.6 million.

Question: 2. What are the VA's plans to meet the Erie VAMC's request for funds to relocate its SPD system in FY 1990?

Answer: The project to relocate SPD is being considered for the FY 1990 minor construction program and has a current total project cost estimate of $928,000.

Question: 3. The parking situation at the VAMC Pittsburgh (University Drive) remains a critical need of that facility. Has the priority ranking of the Pittsburgh project changed since it was reviewed in early 1988? Under the VA's current timeline, does it still expect that the project will come under consideration for FY 1993?

Answer: The priority ranking for this project has not changed; it remains at number 7 of 9 in the parking category. The Pittsburgh medical center's most recently approved five-year plan (FY 1990-1994) indicates a new parking facility as an FY 1991 Advance Planning Fund (APF) project, with construction scheduled for FY 1994, based on current priorities and assuming availability of funds.

Question: 4.a. With regards to the FDP process, it is my understanding that the VA has, beyond the four initial pilot programs conducted to date, already let contracts for 80 FDPs and also intends to contract out for 40 additional FDPs within the next month.

What are the 80 facilities that the VA has already contracted FDPs for and what are the contract costs for each of those facilities? Additionally, what was the total cost for these 80 projects and the average cost for all 80 contracts?

Answer: The following lists 40 facilities contracted for FDPs using FY 1987 funding as well as 40 additional facilities contracted for FDPs in FY 1988. To date, only one fixed-price contract of the fourteen contractors currently working under letter contracts has been negotiated. This contract covers six medical centers at a total cost of $1,714,500, an average cost of $285,750 per VAMC. This cost does not include travel, reproduction and electronic publishing. The remaining thirteen contractors are working under letter contracts averaging $250,000 which is to cover the majority of work for the first facility in each contract group.

Question: 4.b. With regards to the 40 contracts the VA intends to let within the next month, what facilities are involved, what are the contract costs for each (or estimated costs), what is the total cost of the bids received to date for these 40 FDPs and what is the average cost for the 40 bids?

The award of contracts for the 40 FDPs funded in FY 1989 is expected in the fourth quarter of FY 1989. The contractor selection process is now getting underway. Therefore, no bids or proposals to accomplish these FDPs will be received until later this fiscal year. We expect the average cost to complete a basic FDP study and produce a final plan to be in the range of $250,000 to $300,000 each. Below is a list of the 40 medical centers programmed for FDPs in FY 1989.

The remaining FDP's to complete the program are anticipated to be funded and awarded in FY 1990.

SITES FOR FY 1989 FDP DEVELOPMENT

Region 1

Canandaigua, NY
Bath, NY
Batavia, NY
Buffalo, NY
Albany, NY
Syracuse, NY

Region 2

Erie, PA
Beckley, WV
Philadelphia, PA
Pittsburgh (HD), PA
Pittsburgh (UD), PA
Huntington, WV
Wilkes-Barre, PA
Fayettville, NC

Region 3

Lexington, KY
Louisville, KY
Murfreesboro, TN
Nashville, TN
Tuscaloosa, AL
Montgomery, AL

Region 4

Chicago (LS), IL
Hines, IL
Chicago (WS), IL
North Chicago, IL

Region 5

Omaha, NE
Lincoln, NE
Grand Island, NE
Fargo, ND
Sioux Falls, SD
Wichita, KS

Region 6

W. Los Angeles, CA
Portland/Vancouver, Or
Reno, NV
Sepulveda, CA
San Diego, CA
Seattle, WA

Region 7

Fayetteville, AR
Kerrville, TX
Alexandria, LA
San Antonio, TX

SITES FOR PILOT, INHOUSE AND FY 1987 FDP DEVELOPMENT

Region 1

West Haven, CT
Boston, MA and Boston O.P.C.
Bedford, MA
Providence, RI
Brockton, MA
West Roxbury, MA
San Juan, PR (Inhouse)
Northport, NY (Pilot)

Region 2

Butler, PA
Fort Howard, MD
East Orange, NJ
Coatesville, PA
Perry Point, MD
Washington, DC

Region 3

Bay Pines, FL
Tampa, FL
Tuskegee, AL
Miami, FL

Region 4

Ann Arbor, MI
Fort Wayne, IN
Danville, IL
Battle Creek, MI
Saginaw, MI
Marion, IN (Pilot)

Region 5

Kansas City, MO
Hot Springs, SD
Leavenworth, KS
Sheridan, WY
St. Cloud, MN
Topeka, KS
Marion, IL (Pilot)

Region 6

Martinez, CA
American Lake, WA
San Francisco, CA
Spokane, WA
Roseburg, OR
Palo Alto, CA
Long Beach, CA (Pilot)

Region 7

Memphis, TN
Bonham, TX
Muskogee, OK
Prescott, AZ
Shreveport, LA
Tucson, AZ
Waco, TX

SITES FOR FY 1988 FDP DEVELOPMENT

Region 1

Northampton, MA
Montrose, NY
Brooklyn and Brooklyn OPC, NY
New York, NY
Bronx, NY

Region 2

Asheville, NC
Lebanon, PA
Hampton, VA
Salisbury, NC
Lyons, NJ

Region 3

Gainesville, FL
Lake City, FL
Biloxi, MS
Birmingham, AL
Jackson, MS

Region 4

Milwaukee, WI
Madison, WI
Iron Mountain, MI
Cleveland, OH
Cincinnati, OH
Columbus, OH OPC (Independent)

Region 5

Fort Meade, SD
Des Moines, IA
Knoxville, IA
Iowa City, IA
Fort Lyon, CO
Fort Harrison, MT
Miles City, MT

Region 6

Boise, ID
Walla, Walla, WA
Loma Linda, CA
Livermore, CA
White City, OR
Fresno, CA

Region 7

Big Spring, TX
New Orleans, LA
Phoenix, AZ
Oklahoma City, OK
Marlin, TX
Temple, TX

Question: 5.a. The VA intends to complete FDPs for 172 facilities, hiring individual consultants to carry out these reviews of each facility. At the same time the VA's Office of Facilities supports a staff of approximately 800 employees, itself a great source of knowledge and expertise on VA facilities.

Would it have not been more cost efficient for the VA to carry on these facility reviews using in-house capabilities and hiring consultants as may be needed to assist in these efforts than to spend $40+ million to contract out these services, particularly given the VA's own knowledge and expertise of its facilities?

Answer: The Office of Facilites currently has a ceiling of 719 employees 238 of these employees are located in the field supervising construction projects, while another 118 employees are supervising the project management aspect of projects from VACO. When you remove the secretarial and clerical support, budget staff and other administration staff, it would not be possible for the Office of Facilities to begin to complete 172 FDP's in the timeframe we have set. The inhouse method of accomplishing FDP's with assistance from outside consultants is the exact opposite from our ongoing methodology. We assist the contractor with a Management team of VA representatives involving the Medical Center, Medical District, Medical Regional Office and the Office of Facilities. We have found through development of the four pilot FDPs as well as completion of the Stage I portion of a number of ongoing FDP's that our current process is working very well. This process has been confirmed through the evaluation conducted by an independent management consultant. In addition, we have had numerous discussions with health care planning and Architect/Engineering firms as well as visiting with the American Institute of Architects and the American Association of Health Care Consultants to elicit their critique. All avenues of investigation have completely supported our efforts.

Question: 5.b. Did the VA explore this option at any point in carrying out this FDP process?

Answer: We did explore the option of doing FDP's inhouse with support from consultants; however, as stated earlier, our staffing would not allow us to take on such a large endeavor to be completed over a few short years even with some type of support from consultants.

PVA

PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

April 24, 1989

The Honorable G.V. (Sonny) Montgomery, Chairman
House Committee on Veterans' Affairs
334 Cannon House Office Building
Washington, D.C. 20515

Dear Chairman Montgomery:

Enclosed are the answers to questions submitted by the Honorable Bob Stump, regarding the Subcommittee on Hospitals and Health Care hearing of February 1, 1989.

We have provided the answers with some formatting changes, as you requested.

Sincerely yours,

Douglas K. Vollmer (df)

Douglas K. Vollmer
National Legislative Director

DKV/df

Enclosure

801 Eighteenth Street, N.W., Washington, D.C. 20006 (202) USA-1300 Fax: (202) 785-4452

Question

1. Rather than an 86-year replacement cycle, assuming no budget constraints, what would be an ideal replacement cycle for VA hospitals?

Answer

1. 86 Year Replacement Cycle for VA Hospitals: It is not possible to determine the ideal replacement cycle for VA hospitals without the ability to foresee future events. However, with a knowledge of both the current and projected needs of today's veteran population and status of the existing physical structures in the VA medical system, the current need for replacement facilities can and should be determined. There are several factors which influence the decision to replace, renovate, or add to existing medical facilities. Briefly stated, the factors which can result in the need for new construction or a total replacement facility include:

a. Change in Use: VA medical facilities are typically housed in structures built between 1890 and 1989. Specific periods of our history, such as the ten year period following World War II, have resulted in greatly increased construction of medical facilities, often built from a standard or prototype design. Regardless of the date of construction, each VA medical center was originally designed to serve a planned workload of veterans and, in many cases, specific medical missions, for example, TB hospitals in the southwest part of the United States.

Since their original construction, most VA facilities have experienced a significant increase in the number of veterans requiring medical services. The nature of these services has also changed as new medical programs are developed and new procedures for providing these services are established (outpatient clinics, for example). The profile of the user has also changed. In addition to an older veteran population, advances in medicine and new prosthetic devices have resulted in more veterans with injuries who can now continue to live more independent and productive lives. As a result of these changes, today's medical facilities must provide different medical services, usually to a larger veteran population, and meet different design standards such as handicap accessibility requirements.

b. Changes in Medical Equipment: Advances in medical technology have also resulted in new equipment for diagnostics and patient treatment. This equipment has resulted in new requirements for building services such as increased electrical service, higher ceilings in some rooms, higher floor loading capacity, and many different types of protective shielding. In some cases, this has also created the need for dedicated rooms specifically designed to accommodate a specialized piece of equipment.

c. Changes in Design Standards: Technical design standards for the construction of buildings have also been improved. Many of these changes have been related to fire and safety standards. For example, new standards have increased requirements for egress, fire-rated construction, smoke zones, and fire sprinkler systems. Major changes have also occurred in the area of seismic design due to improved engineering and technology.

d. Changes in Building Technical Systems: The technical systems which serve medical buildings have also changed. In the 1950s, the introduction of air conditioning systems required the installation of duct work in most old buildings. Improved forced air heating systems have slowly replaced older hot water radiators. Transportation systems have also changed drastically with improved elevators and many specialized systems for the transport of materials.

Remodeling vs. Replacement: The decision whether to remodel or replace a building or facility must be based on a comparison of the established needs of the medical programs and services and the characteristics of existing structures. Typical factors in this analysis are the floor-to-floor height of the existing building, the column bay-spacing of the existing structural system, and the configuration of the building. For example, most buildings built immediately following World War II did not have air-conditioning. Therefore, the floor-to-floor heights were low and the buildings were configured to maximize the exterior perimeter so natural ventilation could be provided for each room. By today's standards, these linear buildings typically yield less than optimum floor plans, both in terms of heating or cooling costs and staff operations.

Replacement Cycles for Hospitals: Without significant renovation, certainly most structures built in 1903 (86 years ago) would be totally inadequate to serve as a modern medical facility. Many of these buildings, however, can be successfully remodeled or renovated for a different use such as long-term care. The suitability of these facilities for reuse must be based on the needs of the medical center in terms of workload and programs and the associated demands for space and technical capacities. By comparing the requirements with the existing structure, the feasibility of remodeling can be compared to the cost of replacement. When, and if, the VA completes the Facility Development Plans (FDPs) for all medical centers (recommended in 1985), a list of those facilities in need of replacement could be compiled and a reasonable replacement cycle could be established.

Question

2. You note that no new VA nursing home construction is planned for next year and that there is a lack of activation funds for new nursing homes being completed this year. What long-term care implications does this have for the VA?

Answer

2. While current needs for nursing home care for veterans may be met through existing beds or conversion of beds (where possible) nursing home needs of aging veterans will continue to increase for 20-25 years. Need will far outstrip availability of VA beds unless significant construction is undertaken. Conversion of beds is also necessary, but it cannot handle the need, and it does not necessarily exist in the areas of greatest need.

Lengthy planning and construction timetables for VA nursing home beds (up to ten years) mean that construction must start now.

Lack of the necessary VA nursing home beds will mean that the VA will rely more heavily on the more expensive community nursing home beds as much as possible. However, the private sector is expected to experience a shortage of nursing home beds. Eligible veterans may then be denied care. Indigent or low income veterans will almost certainly go without care.

Other long-term effects include the increased use of more expensive modalities of care and increased use of other Federal and State funds such as Medicaid. In addition, competition for beds will create a bidding war and increase costs for both VA and Medicaid nursing home beds.

Question

3. Why do you believe VA construction projects are taking so much longer than those in the private sector?

Answer

3. Delays in the VA Design and Construction Process: The length of time required to plan, design, construct, and activate VA medical facilities is more than twice as long as similar private sector projects. The 1985 study by Booz, Allen, and Hamilton/RTKL indicated that the current design process, from initial programming to final building activation, averaged more than 10 years. Actual construction time (bricks and mortar) for VA projects is comparable to private projects. Therefore, these delays can be directly attributed to the VA's planning and design process. While the Congressional funding cycle is often cited as an important factor which contributes to these delays, private sector projects must also raise construction funds, usually through the sale of bonds. There are several other factors more directly responsible for these delays and, unfortunately, the nature of planning and design process is such that each delay causes further delays. The longer the process is continued, the more the underlying assumptions (the basis for the design) change. The result is a continuing cycle of delays and changes which often result in unwarranted staff work, by the Office of Facilities and medical centers, and excessive design fees paid to architecture and engineering firms. These basic underlying assumptions include:

a. Planning Statistics: Justification for all construction projects lie in the agency's veteran population statistics (number, age, demographics) and current eligibility requirements. Based on actual patient visits and other information, this statistical data is revised annually. Construction projects are currently planned for the year 2000. Within the next two years, the planning basis will shift to the year 2005. The longer it takes to design a project, the higher the probability that statistics will change and the greater the magnitude of changes is likely to be. For example, the Dallas Clinical Project was originally designed in 1984 to accommodate the 246,000 outpatient visits each year. Based on a high patient workload reported in 1986, these projections were revised in 1989 to 380,000 visits annually, an increase of 60%. This figure has since been administratively reduced to 328,000 visits (30% increase). But the increase is still large enough to cause the VA to redesign this complex project at an additional cost in excess of $2 million for architectural and engineering fees.

b. Medical Program Planning: The second underlying assumption for all construction projects is medical program planning. Written plans currently identify specific medical programs such as surgery, spinal cord injury, or nursing home care, which form the current and future basis for each individual medical center's mission. These program plans are part of MEDIPP, which is revised and reviewed on an annual basis. Changes to these program plans impact the design of construction projects both directly and indirectly. A change to the current or long-range mission of the medical center can result in specific adjustments to the scope and design of an ongoing project or can indirectly influence design factors such as site relationships or structural requirements. The longer it takes to design a project, the greater likelihood that medical program plans will change.

c. Criteria: The third underlying assumption for any construction project is space criteria. This criteria determines the size and arrangement of architectural space required to provide support for a specified medical service. Criteria is based on the past experience of the agency and basic assumptions concerning operating modalities and equipment. As new technologies and equipment become available and new medical procedures are established, space criteria must be adjusted. Criteria for any medical department is currently reviewed on a 10 year cycle, but interim changes are made as needed. Most changes in criteria result in adjustments to the size of individual rooms or medical departments that are integral to the design of each project. The longer design takes, the more changes must be made for the building design to meet new criteria.

d. Personnel: The final factor affecting both the time and expense of project development is the role of key personnel and staff at VACO and each medical center. Since it is the VA's policy to tailor each project to the needs and preferences of each medical center, the personal priorities and philosophies of the medical center director, chief of staff, and individual department chiefs significantly influences the architectural design of each project. The longer each project takes to develop, the more changes in personnel will occur as a result of retirement or reassignment. Each newly assigned staff member brings to the project new opinions and ideas which, in most cases, result in design changes.

Conclusions and Recommendations: The network of statistical data, people, and personalities which must be in equilibrium to achieve consensus at each stage of the planning and design process is very fragile. To maintain momentum and consensus, projects must only be expeditiously developed when there is a realistic probability of funding. Allocation of construction resources should be based on the relative needs of the individual medical centers. A long-range plan for resource allocation is not currently possible because the VA does not have the necessary information to establish construction priorities. It should be noted that the VA's FDP Program, which will cost at least 50 million dollars to initiate, will not yield this information for another five years. With these priorities and reasonable estimates for construction costs, projects could be initiated only when there is a realistic expectation of funding. Once detailed design is initiated, design development and construction should be as fast and efficient as possible to minimize changes and the resulting cost overruns.